02/26/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155208	B. WING		01/30/2024
NAME OF T	ADOLUDED OF CURRY TO		STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIEF	t .		LAGRANGE RD	
HANOVE	R NURSING CENT	TER	HANO	VER, IN 47243	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
E 0000					
Bldg					
Ŭ	An Emergency Prep	paredness Survey was	E 0000	Preparation and or the execut	tion
		diana Department of Health in		of this plan does not constitute	
	accordance with 42 CFR 483.73.			admission or agreement by th	
				provider of the truth of the fac	
	Survey Date: 01/30	Date: 01/30/24		alleged or conclusions set for the statement of deficiencies.	
	Facility Number: 0	00115		This plan of correction is prep	ared
	Provider Number: 000113 Provider Number: 155208 AIM Number: 100291080 At this Emergency Preparedness survey, Hanover Nursing Center was found not in compliance with			and or executed solely as	
				required.	
				Toquilou.	
	-	dness Requirements for			
		caid Participating Providers			
	and Suppliers, 42 C				
	The facility has 125	certified beds. At the time of			
	the survey, the cens	sus was 61.			
	Quality Review cor	mpleted on 02/07/24			
		40.070.04.			
	•	42 CFR, Subpart 483.73 is NOT			
	MET as evidenced	by:			
E 0039	403 748/4\/3\ 444	6 E4(d)(2) 418 112(d)(2)			
SS=F		6.54(d)(2), 418.113(d)(2),			
Bldg	. , . ,	2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2),			
Diag		727(d)(2), 485.920(d)(2),			
		1.12(d)(2), 494.62(d)(2)			
	EP Testing Requi				
		18.113(d)(2), §441.184(d)(2),			
		82.15(d)(2), §483.73(d)(2),			
		484.102(d)(2), §485.68(d)(2),			
	. , , , ,	485.727(d)(2), §485.920(d)			
	(2), §491.12(d)(2)				
	(=), 3 [(=)(=)	, 3 (-/(-/-			
	*[For ASCs at §41	6.54, CORFs at §485.68,			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

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.

Stefanie Jenkins

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: QPJ121 Facility ID: 000115 If continuation sheet Page 1 of 54

Administrator

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208		UILDING	NSTRUCTION	(X3) DATE COMPL 01/30	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
PREFIX TAG	PREGULATORY OF OPO, "Organizatic CMHCs at §485.9 §491.12, and ESF (2) Testing. The [fexercises to test to annually. The [fact following: (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the [fact natural or man-male activation of the exercise is exempt from encommunity-based functional exercise actual event. (ii) Conduct an addevery 2 years, oppor functional exercise (i) of this section include, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise (B) A mock disast (C) A tabletop exercise (B) A facilitator	R LSC IDENTIFYING INFORMATION Ons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]: Facility] must conduct the emergency plan cility] must do all of the full-scale exercise that is a every 2 years; or munity-based exercise is onduct a facility-based the every 2 years; or conduct a facility-based the every 2 years; or conducted, that requires the property of the every plan, the [facility] the property of the every plan, the plant of the conducted of the every plant of the conducted of the every plant of the conducted of the following: the property of the every plant of the every plant of the conducted of the following: the property of the every plant of the every plant of the conducted of the following: the property of the every plant of the every plant of the conducted of the following: the property of the every plant of the every plant of the conducted of the conducted of the every plant of the conducted		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	COMPLETION DATE	
	set of problem sta	emergency scenario, and a tements, directed pared questions designed						
	(iii) Analyze the [fa maintain documer	acility's] response to and ntation of all drills, tabletop nergency events, and revise						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet Page 2 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	 UILDING	NSTRUCTION	(X3) DATE COMPI 01/30	LETED
	PROVIDER OR SUPPLIEF		410 W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Irgency plan, as needed.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
	*[For Hospices at (2) Testing for hose the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a commaccessible, condubased functional (B) If the hospice man-made emergof the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an entitle of the conduct of the conduct of the conduct of the community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an entitle conduct of the conduc	418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not lect an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual stional exercise following the gency event. Idditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan.				
	care directly. The	spices that provide inpatient hospice must conduct he emergency plan twice				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 3 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILDING B. WING	ONSTRUCTION	COMPLETED 01/30/2024	
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	(i) Participate in a that is community. (A) When a commaccessible, condufacility-based functions of the emergency exempt from engafull-scale community functional exercise emergency event. (ii) Conduct an actual that may include, following: (A) A second full-community-based functional exercise. (B) A mock disas. (C) A tabletop exefacilitator that inclusing a narrated, emergency scenastatements, direct questions designed emergency plan. (iii) Analyze the himaintain documer exercises, and emergency's emergency's emergency to the hospice's emergency's eme	cunity-based exercise is not ct an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required sity based or facility-based e following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a sudes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared ed to challenge an ospice's response to and intation of all drills, tabletop pregency events and revise or gency plan, as needed.			
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the	PRTF, Hospital, CAH] must to test the emergency ir. The [PRTF, Hospital,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 4 of 54

	NT OF DEFICIENCIES OF CORRECTION			NSTRUCTION	(X3) DATE SURVEY COMPLETED 01/30/2024		
	PROVIDER OR SUPPLIEI			410 W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	that is community	R LSC IDENTIFYING INFORMATION -based; or		TAG	DEFICIENCY)		DATE
	` '	nunity-based exercise is not uct an annual individual,					
	facility-based functional exercise; or						
	-	Hospital, CAH] experiences					
		or man-made emergency					
	i '	vation of the emergency					
	plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:						
	(A) A second full-scale exercise that is						
	community-based						
		ctional exercise; or					
	, ,	ock disaster drill; or					
		p exercise or workshop that tor and includes a group					
	discussion, using						
		emergency scenario, and a					
		atements, directed					
	messages, or pre	pared questions designed					
	to challenge an e						
		he [facility's] response to					
		umentation of all drills,					
	•	s, and emergency events					
	needed.	cility's] emergency plan, as					
	*[For PACE at §4	60 84(d)·1					
		PACE organization must					
	` '	s to test the emergency					
	plan at least annu	5 ,					
	organization must	t do the following:					
		an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 5 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	OF DEFICIENCIES F CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	UILDING	NSTRUCTION		SURVEY LETED 1/2024
	OVIDER OR SUPPLIER		410 W L	DDRESS, CITY, STATE, ZIP CO AGRANGE RD ER, IN 47243	D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION
	facility-based functions (B) If the PACE exor man-made emergency procession and the emergency (ii) Conduct a 2 years opposite to functional exercise of this section is cobut is not limited to (A) A second full-community-based based functional exercise of this section is cobut is not limited to (A) A second full-community-based based functional exercises (C) A tabletop excled by a facilitator discussion, using clinically-relevant set of problem star messages, or prepto challenge an er (iii) Analyze the Pmaintain documer exercises, and em the PACE's emergency procession in the emergenc	reperiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required ity based or individual, tional exercise following the gency event. In additional exercise every the year the full-scale or exercise that may include, to the following: Is cale exercise that is or individual, a facility exercise; or the dill; or ercise or workshop that is and includes a group an anarated, emergency scenario, and a tements, directed that the part of	TAG	DEPCENCE!		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet Page 6 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTI A. BUILD B. WING		STRUCTION	(X3) DATE : COMPL 01/30/	ETED
	F PROVIDER OR SUPPLIEF		4	10 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 R LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	actual natural or na requires activation LTC facility is exe required a full-sca individual, facility-following the onse (ii) Conduct an act that may include, following: (A) A second full-community-based based functional (B) A mock disas (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem star messages, or prepto challenge an ere (iii) Analyze the [I response to and nall drills, tabletop events, and revise emergency plan, at [For ICF/IIDs at § (2) Testing. The IC exercises to test to twice per year. The following: (i) Participate in a that is community (A) When a community (B) If the ICF/IID enatural or man-material response to man-material response function of the ICF/IID enatural or man-material response function of the ICF/IID enatural response function of the ICF/IID enat	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. [483.475(d)]: CF/IID must conduct the emergency plan at least e ICF/IID must do the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 7 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	ľ í	ILDING	NSTRUCTION	(X3) DATE COMPL 01/30	ETED	
	F PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	is exempt from er full-scale community-based function facility-based functions following: (A) A second full-community-based facility-based functions facility-based facility-based facility-relevant set of problem star messages, or preto challenge an el (iii) Analyze the IC maintain document exercises, and en the ICF/IID's eme *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the HH natural or man-matural or man-	rigaging in its next required nity-based or individual, ctional exercise following the gency event. Iditional annual exercise but is not limited to the scale exercise that is or an individual, ctional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. CF/IID's response to and nation of all drills, tabletop nergency events, and revise regency plan, as needed. 34.102] e HHA must conduct he emergency plan at e HHA must do the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 8 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLII		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155208	B. W	ING		01/30	/2024
NIAME OF F	DROWNER OF GUIDNING		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	C		410 W L	LAGRANGE RD		
HANOVE	R NURSING CENT	TER		HANOV	/ER, IN 47243		
(X4) ID		STATEMENT OF DEFICIENCIE	PROVIDER'S PLAN OF CORRECT		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCI		DATE
	onset of the emer	-					
	1 ' '	ditional exercise every 2					
		e year the full-scale or					
	functional exercise under paragraph (d)(2)(i)						
	of this section is conducted, 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 fund						
	1						
	(B) A mock disaster drill; or (C) A tabletop exercise or workshop that						
	is led by a facilitator and includes a group						
	discussion, using a narrated,						
	clinically-relevant emergency scenario, and a						
	set of problem sta						
	· ·	pared questions designed					
	to challenge an er						
		HA's response to and					
	1 ' '	ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §48	36.360]					
	(d)(2) Testing. The	e OPO must conduct					
	exercises to test the	he emergency plan. The					
	OPO must do the	following:					
	(i) Conduct a pape	er-based, tabletop exercise					
	or workshop at lea	ast annually. A tabletop					
	exercise is led by	a facilitator and includes a					
	group discussion,	using a narrated, clinically					
	relevant emergen	cy scenario, and a set of					
	problem statemen	ts, directed messages, or					
	prepared question	is designed to challenge an					
	1	f the OPO experiences an					
		nan-made emergency that					
	requires activation of the emergency plan, the						
	1	om engaging in its next					
		xercise following the onset					
	of the emergency						
	(ii) Analyze the Of	PO's response to and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 9 of 54

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/30/2024	
	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
	exercises, and em the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the conduct a paperat least annually. It is group discussion in arrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emel Based on record reversided 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 a. When a community-based function in the emergency plan from engaging its not community-based of the emergency plan engaging its not community-based of the emer	e RNHCI must conduct the emergency plan. The the following: er-based, tabletop exercise A tabletop exercise is a ted by a facilitator, using a trelevant emergency to fo problem statements, so, or prepared questions the facility response to and thatation of all tabletop the regency events, and revise tregency events, and revise tregency plan, as needed. The facility the facility the recises to test the emergency the recises that the control of the recise that the recise of the re	E 0039	It is the practice of the facility conduct exercises to test the emergency plan annually as outlined in CFR(s): 483.73(d). No residents were negatively affected by the alleged deficie practice. The Maintenance Director and the drills for the activation of the disaster plan. All residents have the potentiable affected by the alleged defipractice. On 2-2-23 Administrator re-educated the Maintenance Director on the requirements activation of the disaster plan. The Administrator will analyze results of the Disaster Plan Activation Drills/Tabletop	ent ded he al to ricient

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 10 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	ì	UILDING	ONSTRUCTION	(X3) DATE COMPL 01/30	ETED
	PROVIDER OR SUPPLIEF			410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, 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)	ATE	(X5) COMPLETION DATE
	functional exercise. b. A mock disaster c. A tabletop exerci facilitator that inclu a narrated, clinically and a set of problem messages, or prepar challenge an emerg (iii) Analyze the LT maintain document exercises, and emer LTC facility's emer accordance with 42 This deficient pract in the facility. Findings include: Based on review of plan on 01/30/24 be with the Maintenan present, the facility documentation of a busted sprinkler pip facility was unable second exercise cor month period. Base record review, the A was no documentat conducted during th	drill; or se or workshop that is led by a ides a group discussion, using y-relevant emergency scenario, in statements, directed red questions designed to ency plan. TC facility's response to and ation of all drills, tabletop regency events, and revise the gency plan, as needed in			Exercises to ensure documentation is maintained those drills, tabletop exercises and emergency events, and rethe emergency plan, as need. The findings will be reported to Monthly QAPI Committee fir a month period and if any patter are identified at the monthly of meeting an action plan will be written by the committee. The action plan will be monitored to the administrator or designee monthly until resolved and substantial compliance is achieved of 100%.	evise ed. o the 112 rns QAPI	
E 0041 SS=F Bldg		(e), 485.625(e) LTC Emergency Power tion for Participation:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet Page 11 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155208	l í	JILDING	NSTRUCTION	COMPL 01/30/	ETED
	PROVIDER OR SUPPLIER			410 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 LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The hospital must standby power systemergency plan s this section and in procedures plan s (i) and (ii) of this s §483.73(e), §485. (e) Emergency and The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency gener generator must be the location required Care Facilities Colliterim Amendment 12-4, TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or buildin 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the eminspection, testing requirements four Facilities Code, Ni Code.	et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. and the CAH] must ency and standby power in the emergency plan set (a) of this section. 63.73(e)(1), §485.625(e)(1) extended in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, did NFPA 110, when a new or when an existing					
	Emergency gener	ator fuel. [Hospitals, CAHs that maintain an onsite fuel					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet Page 12 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208		JILDING	NSTRUCTION	(X3) DATE COMPL 01/30	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, 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 B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE	
	source to power en have a plan for hopower systems on emergency, unless *[For hospitals at §483.73(g), and On the standards incomposed the standards incomposed the section are appreference by the Enderal Register in 552(a) and 1 CFR the material from You may inspect a Information Reson Boulevard, Baltim Archives and Reconformation Reson Boulevard, Baltim Archives Boulevard, Balti	exercises and a second control of the control of th			CROSS-REFERENCED TO THE APPROPE	ENATE		
	(ii) Technical inter NFPA 99, issued (iii) TIA 12-3 to NF 2012.	im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9,						
	2013.	FPA 99, issued March 7, FPA 99, issued August 1,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 13 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING		COMPL	ETED
		155208	B. WING	i		01/30/	/2024
NAME OF P	PROVIDER OR SUPPLIER		S	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
					AGRANGE RD		
HANOVE	R NURSING CENT	ΓER		VONAF	ER, IN 47243		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCE		DATE
	2014.	FPA 99, issued March 3,					
	(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.						
		IFPA 101, issued August					
	11, 2011.						
	(ix) TIA 12-2 to NF	FPA 101, issued October					
	30, 2012.						
	` '	PA 101, issued October					
	22, 2013.	-DA 404 : 10 : 1					
	, ,	FPA 101, issued October					
	22, 2013.	tandard for Emergency and					
		ystems, 2010 edition,					
		chapter 7, issued August 6,					
	2009	mapter 1, issued 1 tagast 6,					
		view and interview, the facility	E 0041	1	It is the practice of this facility	to	03/11/2024
	failed to implement	the emergency power system			implement the emergency power		
	inspection, testing,	and maintenance requirements			system inspection, testing, and	b	
		Care Facilities Code, NFPA			(maintenance) requirements for		
		y Code in accordance with 42			in the Health Care Facilities C		
	CFR 483.73(e)(2).				NFPA 110, and Life Safety Co	de.	
	1 D11				No residents were negatively	4	
		review and interview, the intain a complete written record			affected by this alleged deficie prectice.	ent	
		or load testing for 1 of 1			The Monthly Generator Load		
		of the past 12 months.			testing was completed, and ar	1	
		(a) of 2012 NFPA 99 requires			schedule for the monthly load	•	
	-	the generator serving the			testing created going forward.		
		al system to be in accordance			All residents, staff and visitors		
	· ·	e Standard for Emergency and			have the potential to be affected	ed	
		stems, Chapter 8. Chapter			by this alleged deficient praction		
		requires a written record of			On 2-2-2024 the Administrator	-	
	inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the				re-educated the Maintenance		
					Director on this requirement to)	
					include, a written record of		
	authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site			inspection, performance,	for		
	generators shall be maintained in accordance with				exercising period, and repairs the generator to be regularly	IUI	
	-	dition, Standard for Emergency			maintained and available for		
ı		, ~	1		manitanios una avallable iUl		Ī

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 14 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	A. B	MULTIPLE CO UILDING /ING	NSTRUCTION	(X3) DATE COMPI 01/30	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	storage batteries, in battery voltage, use shall be inspected v compliance with material states and states are shall be inspected v compliance with material states are shall be inspected visitors. Chapter 6. written record of in exercising period, a maintained and avaintained are states and authority having juit practice could affect visitors. Findings include: Based on review of testing reports on 0 2:00 p.m. with the latter was no month documentation avaints september of 2023. There was monthly documentation for 2023, however, their transfer time, or am documented reports there was no cool done documented reports and he has only become and was not able to of monthly load testing the finding was resulted to the shall be added	Systems. 8.3.7 requires cluding electrolyte levels or d in connection with systems weekly and maintained in full anufacturer's specifications. Live batteries shall be repaired ately upon discovery of 5.4.2 of NFPA 99 requires a spection, performance, and repairs shall be regularly ilable for inspection by the risdiction. This deficient at all residents, staff and diameter of the emergency generator. It is generator load test all generator load test allable for January through for the emergency generator. It is generator load test allable for January through for the emergency generator. It is generator load test alloctober through December of the was no percentage of load, aperage readings on the storthose three month, plus, own time listed on the sort. Based on interview at the test, the Maintenance Director en in his current position as tor since September of 2023 find any other documentation ting prior to October of 2023. Viewed with the Administrator firector during the exit			inspection. The Administrator/designee is be responsible for auditing the written record of inspection monthly, the frequency of the ismonthly for 6 months and a issues identified will be addressed and corrected. The findings will be reported Monthly QAPI Committee for months and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	audit any assed to the 6 e I		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet Page 15 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MUL A. BUIL B. WING	DING	NSTRUCTION	(X3) DATE COMPL 01/30/	ETED	
	PROVIDER OR SUPPLIEF			410 W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	facility failed to ensinspections for 1 of for 52 of 52 weeks. NFPA 99 requires the shall be maintained 2010 Edition, Stand Standby Power System batteries, including voltage, used in corresplaced weekly at compliance with m. 8.3.7.2 states defect or replaced immediate defects. Chapter 6. written record of in exercising period, a maintained and avarauthority having just practice could affect visitors. Findings include: Based on review of testing reports on 0. 2:00 p.m. with the latter was no document of the past 52 of the past 53 of the time of record review. This finding was resulting the single propertion of the past 52 of the past 53 of the past 53 of the time of record review.	review and interview, the sure a written record of weekly a generator was maintained Chapter 6-4.4.1.3 of 2012 batteries for on-site generators in accordance with NFPA 110, dard for Emergency and tems. 8.3.7 requires storage electrolyte levels or battery mection with systems shall be and maintained in full anufacturer's specifications. tive batteries shall be repaired ately upon discovery of 5.4.2 of NFPA 99 requires a spection, performance, and repairs shall be regularly ilable for inspection by the risdiction. This deficient et all residents, staff and Maintenance Director present, mentation available to show the for was inspected/tested weekly 2 weeks. Based on interview at eview, the Maintenance there was no weekly locumentation available for viewed with the Administrator birector during the exit					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: QPJ121 Facility ID: 000115

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 01 COMPLETE D. WING				
		155208	B. WI	ING		01/30	/2024
	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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE
K 0000 Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 01/30 Facility Number: 0 Provider Number: 1002 At this Life Safety C Center was found in Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa This one story facility for the facility has a findetection in the corr corridors, plus batte all resident sleeping capacity of 125 and of this visit. All areas where resi were sprinkled and services were sprinkled and services were sprinkled wooden st	200115 155208 291080 Code survey, Hanover Nursing of in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA)101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. Ity was determined to be of ruction and fully sprinkled, re alarm system with smoke ridors and spaces open to the rry operated smoke alarms in grooms. The facility has a had a census of 61 at the time dents have customary access all areas providing facility cled. The facility has a orage garage and a detached busing the emergency re not sprinkled.	K 0	000	Preparation and or the execut of this plan does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set for the statement of deficiencies. This plan of correction is prepand or executed solely as required.	e e ts :h on	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet Page 17 of 54

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155208		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/30/2024			
	PROVIDER OR SUPPLIER ER NURSING CENT		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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SEE COMPLETION DATE		
K 0100 SS=E Bldg. 01	Section 18.1 and that are not addre K-tags, but are de along with the app NFPA standard ciron Form CMS-256 Based on observation failed to ensure 3 of combination ceiling properly maintained all health care facility constructed, maintathe possibility of a servacuation of occup could affect over 25 Findings include: Based on observation p.m. and 5:30 p.m. of the Maintenance Dimounted light and Huntington's Unit by Wing 4 bathroom/sl signs of overheating hard plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored. Based on interview observation, the Maintenance Dimounted light and plastic vents prodiscolored.	nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, blicable Life Safety Code or tation, should be included 67. on and interview, the facility f over 5 bathroom/shower room g light and heater units were d. NFPA 101 at 19.1.1.3.1 states tites shall be designed, ined and operated to minimize fire emergency requiring the bants. This deficient practice or residents, staff, and visitors. The one of 01/30/24 between 2:00 during a tour of the facility with rector, the combination ceiling meater units in the bathroom/shower room (x1) and hower room (x2) were showing g due to the appearance of the artially melting/warping and	K 0100	It is the practice of this facili ensure ceiling lights and her units are properly maintaine No residents were affected alleged deficient practice. On 2-12-24 the ceiling mour light and heater unit in the bathroom on the Huntington Disease Unit was replaced On 2-12-24 the two hard play vents were replaced located Wing 4 bathroom/shower room This alleged deficient practic the potential to affect over 2 residents, staff, and visitors. The Maintenance Director conducted rounds and replay other lights, heater units and as identified. On 2-2-24 the Administrator re-educated the Maintenance Director on ensuring to iden areas and correct them to minimize the possibility of a emergency requiring the evacuation of occupants. A staff re-educated on identify areas and reporting those a ensure the risk of a fire emerging minimized by 2-26-24.	ater ad. by this by this nted d's astic d on om ce has 55 aced d vents ce tify fire Il other ring reas to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 18 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		, ,	ULTIPLE CO	onstruction 01	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155208	B. WI		<u>01</u>	01/30	
	PROVIDER OR SUPPLIE			410 W I	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
	conference. 3.1-19(b)				The Maintenace will conduct Safety Rounds in 10 separate areas weekly; including reside rooms, storage areas, offices, common areas and bathroom issues identified will be corre upon discovery. Fire Safety Rounds will be completed wer for 4 weeks, every other wee 8 weeks and monthly for 8 weeks and monthly for 8 weeks and monthly GAPI Committee and any patterns are identified at a monthly QAPI meeting an act plan will be written by the committee. The action plan where the monitored by the administror designee monthly until resonant substantial compliance is achieved 95% or greater.	e ent , s; cted ekly k for eeks. o the d if the ion vill rator	
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking ar CLINICAL NEED LOCKING Where special locklinical security in used, only one lopermitted on each be made for the respective sides.	ed means of egress shall not a latch or a lock that of a tool or key from the is using one of the following rangements: S OR SECURITY THREAT obtains arrangements for the eeds of the patient are cking device shall be in door and provisions shall apid removal of occupants of of locks; keying of all					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 19 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	ì	UILDING	nstruction 01	(X3) DATE COMPI 01/30	LETED		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243						
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION		
	,				CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE			
TAG	locks or keys carrother such reliable staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special loc safety needs of the Clinical or Secare being met. In electrical locks the release upon loss building is protect automatic sprinkle space is protected detection system at an attended loc space); and both systems are arrar upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies servir contents in buildir an approved, sup detection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTELOCKING ARRAI Access-Controlled installed in accord be permitted.	R LSC IDENTIFYING INFORMATION ied by staff at all times; or e means available to the 2.2.2.6, 19.2.2.2.5.1, LOCKING S cking arrangements for the e patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised er system and the locked d by a complete smoke (or is constantly monitored cation within the locked the sprinkler and detection nged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING S delayed-egress locking in accordance with permitted on door ng low and ordinary hazard ngs protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 ROLLED EGRESS NGEMENTS d Egress Door assemblies dance with 7.2.1.6.2 shall		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	KOPKIATE	DATE		
	18.2.2.2.4, 19.2.2 ELEVATOR LOBI	BY EXIT ACCESS							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet Page 20 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPLE	
		155208	B. WI	NG		01/30/2	2024
	PROVIDER OR SUPPLIER		•	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	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	LOCKING ARRAN	NGEMENTS					
		t access door locking in					
	accordance with 7	7.2.1.6.3 shall be permitted					
		es in buildings protected					
	throughout by an approved, supervised automatic fire detection system and an						
		sed automatic sprinkler					
	system. 18.2.2.2.4, 19.2.2.2.4						
		ration and interview, the	K 02	222	1 '		03/11/2024
		sure the means of egress			ensure the means of egress a		
	through 1 of 11 locked exit doors was readily				readily accessible for resident	.,	
		ents, staff, and visitors. This			staff and visitors.		
	•	ould affect at least 20 residents,			No residents were negatively		
	as well as staff and	visitors.			affected by this alleged deficie	ent	
					practice.		
	Findings include:				The code to activate the door		
	.	01/20/241			release is now posted on the		
		ons on 01/30/24 between 2:00			frame for the exit door to Wing	3	
		during a tour of the facility with			smoking area.		
		rector, the Huntington's Unit			The code to activate the door	d	
		nagnetically locked and could entering a code on a keypad			release is now posted on the		
		the exit door. Based on			frame for the south exit door o	ווי	
	· ·	e of observation, when asked,			Wing 4 corridor.	,	
		rector did not know the code			The code to activate the door now posted on the door frame	I	
		from the magnetic lock. He			the service hall east exit door.		
		least three nursing staff and			The code was reprogrammed		
	one housekeeping s	_			the exit door located on Wing		
		f they knew the code to open			and staff is aware of the code		
		nembers knew the code. The			This alleged deficient practice		
		e from the magnetic locking			the potential to affect at least		
		e alarm system was activated at			residents, as well as staff and		
	4:30 p.m.				visitors.		
					On 2-2-24 the Administrator		
	This finding was re	viewed with the Administrator			re-educated the Maintenane		
		irector during the exit			Director on the egress door		
	conference.	5			CFR(s): NFPA 101, related to		
					ensuring the means of egress		
	3.1-19(b)				readily accessible for resident		

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2024		
	ROVIDER OR SUPPLIER			410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, 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)	TE	(X5) COMPLETION DATE
	2. Based on observe facility failed to ensist through 3 of 11 exirces idents without a specialized security required means of exit a latch or lock or key from the egree permitted by LSC 1 arrangements shall with 19.2.2.2.5.2. affect at least 20 respecting to exit the exit door to a sea of the manner of the maintenance of the maintenan	ration and interview, the sure the means of egress ts was readily accessible for clinical diagnosis requiring measures. Doors within a egress shall not be equipped that requires the use of a tool ess side unless otherwise 19.2.2.2.4. Door-locking be permitted in accordance This deficient practice could sidents, staff and visitors facility. The sum of the facility with irector, the following was the Wing 3 employee smoking with the code to actuate the coor from the Wing 4 corridor in the code to actuate the door least exit door was posted with the actuate the door release. The time of each cantenance Director codes either not posted or ted at the previously			staff and visitors. All other staff be re-educated by 2-26-24. The Administrator will conduct weekly Egress Door Rounds of exit doors to ensure the proper postings are on exit doors; undiclinical needs or security threat The rounds will be conducted weekly or 8 weeks, every other week for 8 weeks and monthly monthly for 8 weeks, any issue identified will be corrected upon discovery. The findings will be reported to Monthly QAPI Committee and any patterns are identified at the monthly QAPI meeting an actipation will be written by the committee. The action plan with the monitored by the administrator designee monthly until resoluted and substantial compliance is achieved 95% or greater.	t on all r ess it. r r and es on the if ne on	
	J.1-19(U)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 22 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155208	B. W	ING _		01/30/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIER	t .			LAGRANGE RD		
HANOVE	ER NURSING CENT	ER			/ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
K 0293	NFPA 101						
SS=E	Exit Signage						
Bldg. 01	Exit Signage						
	2012 EXISTING						
	Exit and directions	al signs are displayed in					
	accordance with 7	7.10 with continuous					
	illumination also s	erved by the emergency					
	lighting system.						
	19.2.10.1						
	(Indicate N/A in or	ne-story existing					
	occupancies with	less than 30 occupants					
	where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 3 doors to the courtyard						
			K 0293		·		03/11/2024
					have exit and directional signs		
	could not be mistak	ould not be mistaken as a facility exit. LSC			displayed with continuous		
	7.10.8.3.1 states any	y door, passage, or stairway			illumination also served by the	;	
	that is neither an ex	it nor a way of exit access and			emergency lighting system.		
		ranged so that it is likely to be			No residents were negatively		
		t shall be identified by a sign			affected by this alleged deficie	ent	
		s: NO EXIT. The NO EXIT			practice.		
	_	word NO in letters 2 inches			On 2-12-24 an exit sign was		
	_	width of 3/8 inch, and the word			installed for the West entrance	e to	
		ord NO, unless such sign is an			the Huntington Disease Unit.		
		ign. This deficient practice			This alleged deficient practice		
		10 residents, as well as staff			the potential to affect 10 resident	ents,	
	and visitors.				as well as staff and visitors.		
					On 2-12-24 the Maintenance		
	Findings include:				Director conducted rounds on		
					exits to ensure the exit/direction		
		ons on 01/30/24 between 2:00			signs are displayed and in wo	_	
		during a tour of the facility with			order; no discrepancies noted		
		rector, the north outside door			On 2-2-24 Administrator		
		ar the west entrance to the			re-educated the Maintenance		
		was not posted with a NO			Director on exit signage regula		
		on interview at the time of the			to ensure exit/directional signs	are	
		intenance Director said this			displayed with continuous		
		ired exit and agreed there			illumination served by the		
	should be a "NO EX	XIT" sign on the door.			emergency lighting system an		
					other staff will be re-educated	-	
	This finding was re	viewed with the Administrator			2-26-24. The Administrator w	ill	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 23 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		 JILDING	nstruction <u>01</u>	(X3) DATE COMPL 01/30 /	ETED	
	PROVIDER OR SUPPLIER		410 W L	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)	ΓE	(X5) COMPLETION DATE
	and Maintenance D conference. 3.1-19(b)	irector during the exit		conduct weekly Exit Signage Rounds on all exit doors to ensithe proper postings are on exit doors; unless clinical needs or security threat. The rounds wi conducted weekly or 8 weeks, every other week for 8 weeks, every other week for 8 weeks monthly and monthly for 8 wee any issues identified will be corrected upon discovery. The findings will be reported to Monthly QAPI Committee and any patterns are identified at th monthly QAPI meeting an actio plan will be written by the committee. The action plan wi be monitored by the administra or designee monthly until reso and substantial compliance is achieved 95% or greater.	Il be and eks, the if ne on	
K 0321 SS=E Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extii accordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 5.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 24 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				ETED
		155208	B. WI	2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel	-Fired Heater Rooms					
	c. Repair, Mainter d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe	lons) orage Rooms/Spaces eet) classified as Severe					
	Based on observation failed to ensure 1 or such as a storage rowelf-closing device. affect up to 10 resident periods include: Based on observation periods and 5:30 p.m. the Maintenance Dispense used as a store The room was over contained at least 30 boxes. The corridor provided with a self-confirmed by the Moof observation. This finding was resulted as a store that the self-confirmed by the Moof observation.	on and interview, the facility f over 20 hazardous area doors, om door, was provided with a This deficient practice could	K 0.	321	It is the practice of this facility ensure hazardous area doors self-closing or automatic-closin No residents were negatively impacted by this alleged praction 2-12-24 items were remove from the room and relocated to designated storage room equil with self-closing door. This alleged deficient practice the potential to affect up to 10 residents and staff. On 2-12-24 Maintenace Direct conducted rounds to ensure nother non-authorized storage rooms are storing hazardous supplies. The 2-2-24 the Administrator re-educated the Maintenance Director on the enclosure of hazardous areas and all other	are ng. ice. ed o a pped has	03/11/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 25 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155208	B. WI	NG		01/30/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER		410 W LAGRANGE RD				
HANOVE	R NURSING CENT	FR	HANOVER, IN 47243				
T					,		
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conference.				re-educated by 2-26-24. The		
	2.1.10(1.)				administrator will conduct wee	-	
	3.1-19(b)				Enclosure for Hazardous Area		
					Rounds on all exit doors to en		
					the proper postings are on exi		
					doors; unless clinical needs or		
					security threat. The rounds wi conducted weekly or 8 weeks,		
					every other week for 8 weeks		
					monthly and monthly for 8 weeks		
					any issues identified will be	ono,	
					corrected upon discovery.		
					The findings will be reported to	the	
					Monthly QAPI Committee and		
					any patterns are identified at the		
					monthly QAPI meeting an action		
					plan will be written by the		
					committee. The action plan w	ill	
					be monitored by the administra		
					or designee monthly until reso		
					and substantial compliance is		
					achieved 95% or greater.		
					-		
K 0345	NFPA 101						
SS=F	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance						
	Fire Alarm System	n - Testing and					
	Maintenance						
	-	n is tested and maintained					
		n an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		m and Signaling Code.					
	and testing are rea	n acceptance, maintenance					
	9.6.1.3, 9.6.1.5, N	•					
		review and interview, the	K 0.	2.15	It is the practice of this facility	on	03/11/2024
		intain 1 of 1 fire alarm system in	K U.	∪+ ∪	a semi-annual basis to visually		U3/11/202 4
		FPA 72, as required by LSC 101			inspect the fire alarm system a		
	ascordance with M	111 , 2, as required by 1500 101				ai i u	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 26 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			ETED	
		155208	B. W	B. WING 01/30/2024			
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	t.			LAGRANGE RD		
HANOVE	R NURSING CENT	ER		HANOVER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		and 9.6. NFPA 72, Section			ensure the records of system		
		aless otherwise permitted by			acceptance, maintenance and	ı	
	_	ctions shall be performed in			testing are readily available.		
		e schedules in Table 14.3.1, or			No residents were negatively	4	
	_	ed by the authority having 14.3.1 states that the following			affected by this alleged deficie	ent	
	1 ·	spected semi-annually:			practice. The vendor (IEI) was contacted	ed to	
	a. Control unit troul	-			schedule the semi-annual visu		
	b. Remote annuncia	_			inspection of the fire alarm sys		
	c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors,				This alleged deficient practice		
					the potential to affect at least		
	etc.)				residents, as well as staff, and		
	d. Notification appliances				visitors.	•	
	e. Magnetic hold-open devices				On 2-2-2024 the Administrato	r	
	This deficient practice could affect all occupants				re-educated the Maintenance		
	in the facility.	•			Director on completing		
					semi-annual inspections of the	e fire	
	Findings include:				system with the supportive		
					documentation. The Administ	rator	
	Based on record rev	view on 01/30/24 between 9:45			will review the documentation	after	
	a.m. and 2:00 p.m.	with the Maintenance Director			completion of both inspections	6	
	present, there was d	locumentation provided			conducted annually.		
	regarding an annual	fire alarm system inspection			The findings will be reported to	o the	
	I	he facility's fire alarm			Monthly QAPI Committee and	if	
		nowever, there was no			any patterns are identified at t	he	
		lable to show that a			monthly QAPI meeting an acti	on	
		inspection of the facility's fire			plan will be written by the		
		performed about six months			committee. The action plan w		
		alarm system inspection.			be monitored by the administr		
		at the time of record review,			or designee monthly until reso		
		rector confirmed there was no			and substantial compliance is		
		inspection of the facility's fire			achieved 100%.		
	alarm system device	es available to review.					
	This finding was re	viewed with the Administrator					
		irector during the exit					
	conference.						
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 27 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILDING 01 B. WING		COMPLETED 01/30/2024		
	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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
	2. Based on observe facility failed to may in accordance with 101 Sections 19.3.4 14.3.1 states that und 14.3.2, visual inspersaccordance with the more often if requiringuisdiction. Table must be visually insurable a. Control unit trouble in the control unit trouble in the control unit trouble. Remote annunciated in the control unit trouble in the control unit trouble. Remote annunciated in the control unit trouble in the control unit trouble. A service of the control unit trouble in the control unit trouble in the control unit trouble. A service of the control unit trouble in the co	ation and interview, the intain 1 of 1 fire alarm systems NFPA 72, as required by LSC .5.1 and 9.6. NFPA 72, Section aless otherwise permitted by ections shall be performed in eschedules in Table 14.3.1, or red by the authority having 14.3.1 states that the following spected semi-annually: ble signals attors (e.g. duct detectors, manual eat detectors, smoke detectors, iances been devices ice could affect at least 10 a staff, and visitors. Ons on 01/30/24 between 2:00 during a tour of the facility with rector, the ceiling mounted he Wing 4 corridor outside ang from its wires about three ling. Based on interview at the the Maintenance Director moke detector hanging by its				
K 0353 SS=F	NFPA 101 Sprinkler System	- Maintenance and Testing				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 28 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/30/2024	
	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
Bldg. 01	Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record interview; the facility system inspections for 1 of 1 dry sprink past 52 weeks for the gauges, and during sprinkler system's c Standard for the Instantance of Wa Systems, 2011 Editing gauges on dry pipe inspected weekly to water pressures are 5.1.2 states valves a connections shall be maintained in according section 13.1.1.2 states utilized for inspectivalves, valve compostates records shall be maintained in according states records shall be section 13.1.1.2 states records shall in the section of the section 13.1.1.2 states records shall be section 13.1.1.2 states records shall in the section of the section 13.1.1.2 states records shall in the section of the	supply source RKS information on non-required or partial r system. and NFPA 25 review, observation, and ty failed to document sprinkler in accordance with NFPA 25 ther system during 36 of the ne sprinkler system's pressure 2 of the past 12 months for the control valves. NFPA 25, pection, Testing, and ter-Based Fire Protection ion, Section 5.2.4.2 states sprinkler systems shall be ensure that normal air and being maintained. Section	K 0353	It is the practice of this facility complete the maintenance and testing of the automatic sprink and standpipe systems in accordance with NFPA 25. No residents were negatively affected by this alleged deficie practice. On 2-20-24 the Maintenace Director started inspecting the facility's dry sprinkler system gauges. On 2-20-24 the Maintenace Director started monthly sprint system control valves. On 2-20-24 the escutcheon rir the sprinkler head located in the Service Hall outside the Launc Room was resecured, no gap around the sprinkler pipe throuther ceiling.	d ler ent kler ng in ne dry

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 29 of 54

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		î î	A. BUILDING <u>01</u>		(X3) DATE SURVEY COMPLETED 01/30/2024	
	ROVIDER OR SUPPLIER		410	EET ADDRESS, CITY, STATE, ZIP COD W LAGRANGE RD NOVER, IN 47243		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	TION LD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		ROPRIATE	DATE
	•	all be made available to the		On 2-20-24 the escutched	~	
		risdiction upon request. This		replaced in the kitchen ne		
	_	ould affect all residents, staff,		dishwashing area , no ga	p around	
	and visitors in the fa	acılıty.		the sprinkler pipe		
				On 2-20-24 the 2, 2-to-3-		
	Findings include:			holes in the ceiling repair	ed by the	
	D 1 1	. 01/20/241		Physical Therapy closet.		
		review on 01/30/24 between		On 2-20-24 the sprinkler		
		p.m. with the Maintenance ere was no documentation		support rods in Wing 4 co	orridor the	
	•			gaps were repaired.	h - l i -	
	available to show the facility's dry sprinkler system gauges were inspected weekly during 36 of the past 52 week period. Based on interview at			On 2-20-24 the 3, 3-inch		
				the ceiling were repaired. Contractor scheduled for		
	the time of record review, the Maintenance Director confirmed there was no documentation					
				to resolve the issues iden the electrical room.	iunea m	
		nat the facility's sprinkler			otico boo	
		aspected at least weekly		This alleged deficient pra the potential to affect all r		
		st 52 weeks. Based on		staff, and visitors.	esiderits,	
		ne Maintenance Director		On 2-2-24 the Administra	tor	
		facility between 2:00 p.m. and		reeducated the Maintena		
	-	y had four pressure gauges at		Director on the maintenar		
	the sprinkler riser.	y had four pressure gauges at		testing of the automatic s		
	the sprinkler riser.			and standpipe systems.	prinkici	
	b. Based on record	review on 01/30/24 between		The Maintenance Directo	r will	
		p.m. with the Maintenance		conduct weekly Sprinkler		
		ere was no monthly sprinkler		to include, no gaps aroun		
	-	es inspection documentation		no holes in ceiling, electri		
	•	months (February and March		conduit/wires not resting		
	•	terview at the time of record		sprinkler piping and escu		
		nance Director confirmed the		rings are in place, for 8 w		
		stem inspections on the control		every other for 8 weeks a		
		f the past 12 months.		monthly for 8 weeks, any		
	_			identified will be corrected		
	This finding was re	viewed with the Administrator		discovery.	•	
		irector during the exit		The findings will be repor	ted to the	
	conference.			Monthly QAPI Committee		
				any patterns are identified		
	3.1-19(b)			monthly QAPI meeting ar		
				plan will be written by the		
	2. Based on observ	ation and interview, the		committee. The action pl		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			ETED	
		155208	B. W	B. WING			01/30/2024	
					_			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					LAGRANGE RD			
HANOVE	ER NURSING CEN	TER		HANOV	/ER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIPED IN AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE	
	facility failed to en	sure the ceiling in 3 of 9			be monitored by the administra	ator		
		compartments was maintained			or designee monthly until reso			
	_	heads to function to their full			and substantial compliance is			
	_	eficient practice could affect at			achieved 95% or greater.			
	least 20 residents, s				derneved 66 % or greater.			
	,	,						
	Findings include:							
	Based on observati	ions on 01/30/24 between 2:00						
		during a tour of the facility with						
		Director, the following was						
	noted:	needed, and lone wing was						
		ring in the sprinkler head in						
		itside the Laundry Room was						
		east one inch which created a						
		round the sprinkler pipe						
	through the ceiling							
		ring was missing from the						
		ne kitchen near the dishwashing						
	_	a one half inch gap around the						
	sprinkler pipe thro	-						
		, 2 to 3 inch holes in the ceiling						
	-	Therapy closet where piping						
		tener used to run through the						
	ceiling.							
		east eight sprinkler pipe support						
		corridor between rooms 56 and						
		cheons from the support rods						
		ch created a 1/4 inch to 1/2 inch						
		iling around each support rod.						
		Room had three, three inch holes						
	_	around wires, one around a						
	conduit, and one th	_						
		at the time of each						
		aintenance Director						
		gaps penetrating the						
	previously mention	ned ceiling areas.						
		eviewed with the Administrator						
	and Maintenance I	Director during the exit						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet Page 31 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. B	MULTIPLE CO UILDING 'ING	(X3) DATE COMPI 01/30	LETED				
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
TAG	conference. 3.1-19(b) 3. Based on observe facility failed to make in accordance with for the Inspection, Water-Based Fire Fedition, Section 5.2 not be subjected to either resting on the This deficient practithe Electrical Room. Findings include: Based on observating p.m. and 5:30 p.m. the Maintenance Define was a two to the emerging from a late conduit protruded of about four feet and room approximated. There were three elform the conduit armetal box was tethed zip ties. Based on observation, the Makenowledged the feethered to the spring he had no idea why box were protruding would call an electric description.	vation and interview, the sintain 1 of 1 sprinkler systems NFPA 25. NFPA 25, Standard Testing, and Maintenance of Protection Systems, 2011 a.2.2 states sprinkler piping shall external loads by materials are pipe or hung from the pipe. Since could affect staff while in a ons on 01/30/24 between 2:00 during a tour of the facility with irrector, in the Electrical Room of the electrical bank. The metal bout from the electrical bank then turned and ran across the yone foot below the ceiling. The ered to a sprinkler pipe with two interview at the time of the aintenance Director metal box with electrical wires and said the conduit, wires, and metal g from the electrical bank, but rician to correct the issue.		TAG	OROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRI	ROPKIATE	DATE		
		viewed with the Administrator birector during the exit							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 32 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING O1 O1/20/2024				ETED	
		155208	B. WI	NG		01/30/	2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	3.1-19(b)						
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting of than required enclosexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. T apply to auxiliary s flammable or combustible mater covering is not exc doors complying w if provided with a c the door closed wh applied. There is a closing of the door release when the c permitted. Nonrate unlimited height ar meeting 19.3.6.3.6 frames shall be lat other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrice	g fire for at least 20 fully sprinklered smoke only required to resist the . Corridor doors and doors g flammable or rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor reeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are and protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 33 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	` <i>'</i>			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u> COMPLETED			ETED
		155208	B. WING 01/30/2024				
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8	410 W LAGRANGE RD				
HANOVE	R NURSING CENT	ER			/ER, IN 47243		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TING INFORMATION TAG		DEFICIENCY)		DATE
		Parts 403, 418, 460, 482,					
	483, and 485	(O details of decomposition					
	Show in REMARKS details of doors such as						
	-	ngs, automatics closing					
	devices, etc.	ation and interview, the	IZ O	262	It is the practice of this facility	to	02/11/2024
			K 0	303	It is the practice of this facility ensure corridor doors have no		03/11/2024
	facility failed to ensure 1 of 2 kitchen corridor doors had no impediment to closing. This deficient practice could affect mostly staff in the Service Hall. Findings include: Based on observations on 01/30/24 between 2:00						
					impediment to closing and en		
					resident room corridor doors close completely and latch into its door frame. No residents were negative affected by this alleged deficient		
					practice.	IL	
		during a tour of the facility with			During the tour the door wedg	ie	
		rector, the right side door to			was immediately removed for		
		e Service Hall was held open			kitchen corridor door.		
		Based on interview at the time			On 2-7-24 the hinges were		
	_	Maintenance Director			tightened to the corridor door	to	
		loor wedge holding open the			resident room 26, door now		
		oor to the Service Hall.			completely close and latch int	0	
	-				the door frame		
	This finding was re	viewed with the Administrator			On 2-7-24 a locking knob was	;	
	and Maintenance D	irector during the exit			installed on the left side kitche		
	conference.				door from the service hall and	door	
					closes and latches automatica	ally.	
	3.1-19(b)				This alleged deficient practice		
					the potential to affect up to 20		
		ation and interview, the			residents, staff and visitors.		
		sure 1 of 71 resident room			The Maintenance Director will		
		d close completely and latch			conduct Rounds on Corridor I	Doors	
	· ·	and 1 of 2 kitchen doors was			to ensure that there are no		
	_	deadbolt lock. This deficient			impediment to closing and the	-	
	-	t over 20 residents, staff and			close completely and latch, ar		
	visitors.				issues will be addressed upor	1	
					discovery.		
	Findings include:				On 2-2-24 the Administrator		
		01/00/041			re-educated the Maintenance		
		ons on 01/30/24 between 2:00			Director on corridor doors to		
p.m. and 5:30 p.m. during a tour of the facility with				ensure there are no impedime	ent to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 34 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURV COMPLETED 01/30/202)
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP C LAGRANGE RD VER, IN 47243	OD	
(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 CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION OULD BE PPROPRIATE CO	(X5) MPLETION DATE
	noted: a. The corridor door not easily close conframe. The door ha its door frame to clothe top of the door who is the top of the door to be the top of the door to clothe top of the door to easily close compliance and the deadly kitchen door. This finding was recompliance to consider the contraction of the door.	then door from the Service Hall a deadbolt lock which did not ose and latch automatically. adbolt lock was loose and ly locked. at the time of each		closing and they close and latch automatically Maintenance Director of Corridor Door Audits weeks, every other weeks and monthly for any issues identified we corrected upon discover The findings will be rep Monthly QAPI Committed any patterns are identified monthly QAPI meeting plan will be written by the committee. The action be monitored by the action of designee monthly ur and substantial complications.	. The vill conduct eekly for 8 ek for 8 8 weeks, vill be ery. orted to the ee and if ied at the an action he plan will ministrator ntil resolved ance is	
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that r Nonrated protectiv are permitted. Doo fixed fire window a are self-closing or require latching, a	Iding Spaces - Smoke Iding Spaces - Smoke				

03/01/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2024 155208 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD HANOVER NURSING CENTER HANOVER, IN 47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 1. Based on observation and interview, the K 0374 03/11/2024 It is the practice of this facility to facility failed to ensure 2 of 11 sets of smoke ensure that all smoke barrier barrier doors would close completely to form a doors close completely to form a smoke resistant barrier. LSC, Section 19.3.7.8 smoke resistant barrier and fire requires that doors in smoke barriers shall comply rated tags not covered by paint. with LSC, Section 8.5.4. LSC, Section 8.5.4.1 No residents were negatively requires doors in smoke barriers to close the affected by the alleged deficient opening leaving only the minimum clearance practice. necessary for proper operation which is defined On 2-23-24 the smoke barrier as 1/8 inch to restrict the movement of smoke. doors were inspected by Regional This deficient practice could affect at least 20 Maintenance Director and residents, as well as staff and visitors. identified new closures needed and ordered the closures. Findings include: On 2-20-24 the Maintenance Director ensured fire testing tags Based on observations on 01/30/24 between 2:00 located on Wing 3 no longer are p.m. and 5:30 p.m. during a tour of the facility with covered by paint. the Maintenance Director, the following was This alleged deficient practice has the potential to affect 20 residents, a. The set of smoke barrier doors at the north end as well as staff and visitors. of the Wing 4 corridor would not close completely The Maintenance Director and when tested. There was a one inch gap between Regional Maintenance Director the doors when closed fully. conducted rounds on all smoke b. The south door of the set of smoke barrier barrier doors close completely to doors near the DON office did not close fully form a smoke resistant barrier and when tested. There was a one inch gap between other fire rated tags are not the doors when closed fully. The south door was covered by paint, any issues were sticking at the top of the door frame. corrected upon discovery. This was acknowledged by the Maintenance On 2-2-24 the Administrator Director at the time of each observation. re-educated the Maintenace Director on compliance with This finding was reviewed with the Administrator smoke barrier doors; specifically and Maintenance Director during the exit related to ensuring they close conference. completely to form a smoke resistant barrier and fire rated tags 3.1-19(b) will not be covered by paint. The Maintenance Director will

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 36 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155208	B. W	ING		01/30/	2024
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			_AGRANGE RD		
HANOVE	R NURSING CENT	TER			/ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ration and interview, the			complete the Smoke Barrier a		
	-	sure 2 of 11 sets of smoke			Fire Rated Tag audit tool weel	-	
	barrier doors did not have paint on the fire rating tags to ensure the doors would resist fire for at				for 8 weeks, every other week		
					weeks and monthly going forw	ard;	
		SC, Section 19.3.7.8 requires			any issues identified will be		
		barriers shall comply with			addressed immediately.		
		This deficient practice could			The findings will be reported to		
		sidents, as well as staff and			Monthly QAPI Committee and		
	visitors.				any patterns are identified at the		
					monthly QAPI meeting an action	on	
	Findings include:				plan will be written by the		
		01/00/041			committee. The action plan w		
		ons on 01/30/24 between 2:00			be monitored by the administra		
	p.m. and 5:30 p.m. during a tour of the facility with				or designee monthly until reso	lved	
		rector, the following was			and substantial compliance is		
	noted:	4			achieved 95% or greater.		
		n the set of smoke barrier					
	_	corridor leading to the					
		aint covering the fire rating tag.					
		e set of smoke barrier doors in					
	_	near rooms 43 and 44 had					
	paint covering the f	at the time of observations,					
		rector acknowledged the paint					
		ting tags on the sets of smoke					
	barrier doors.	ting tags on the sets of smoke					
	barrier doors.						
	This finding was re	viewed with the Administrator					
		irector during the exit					
	conference.	nector during the exit					
	comerciae.						
	3.1-19(b)						
K 0511	NFPA 101						
SS=E	Utilities - Gas and	Flectric					
Bldg. 01	Utilities - Gas and						
ומק. U ו							
		gas or related gas piping PA 54, National Fuel Gas					
	•	iring and equipment					
		PA 70, National Electric					
	Combines with MEL	A 10, National Electric	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 37 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2024 155208 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD HANOVER NURSING CENTER HANOVER, IN 47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility K 0511 03/11/2024 It is the practice of this facility to failed to ensure electrical wiring was protected in 3 ensure electrical wiring is of 9 smoke barriers. NFPA 70, 2011 Edition. protected and overall compliance Article 406.6, Receptacle Faceplates (Cover with NFPA 70 Plates), requires receptacle faceplates shall be No residents were negatively installed so as to completely cover the opening affected by the alleged deficient and seat against the mounting surface. NFPA 70, practice. 2011 Edition. Article 406.5 (F) Exposed Terminals, On 2-12-24 the ceiling light in the Receptacles shall be enclosed so that live wiring Maintenance Shop was replaced terminals are not exposed to contact. and not hanging by wires. This deficient practice could affect at least 20 On 2-12-24 on Wing 4 corridor residents, staff, and visitors. between rooms 56 and 72 light fixtures installed and no wires Findings include: exposed or hanging down from the Based on observation on 01/30/24 between 2:00 On 2-12-24 the loose receptacle in p.m. and 5:30 p.m. during a tour of the facility with Room 105 was tightened and is the Maintenance Director, the following was flush to the wall. On 2-12-24 the loose receptacle in a. The Maintenance Office/Shop had a light Wing 1 Dining Room was hanging from the ceiling from its wires. tightened and is flush to the wall. b. The Wing 4 corridor between rooms 56 and 72 This alleged deficient practice has had three areas on the ceiling where light fixtures the potential to affect at least 20 used to be that had wires exposed and hanging residents, staff, and visitors. down at least six inches. The Maintenance Director c. Room 105 had a loose receptacle and hung out conducted rounds of the facility from the wall about a half inch. The receptacle and any identified loose receptacle had tape on it trying to keep it on the wall. and/or exposed wires identified d. The Wing 1 Dining Room had a loose were immediately addressed. receptacle hanging out from the wall about a half On 2-2-24 the Administrator reeducated the Maintenance Based on interview at the time of each Director on ensuring electrical observation, the Maintenance Director wiring is protected and in acknowledged the aforementioned conditions. compliance with NFPA 70, National Electric Code. All other This finding was reviewed with the Administrator staff also will be in-serviced by and Maintenance Director during the exit 2-26-24 on NFPA 70 and

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPI A. BUILDIN B. WING	ng <u>01</u>	(X3) DATE S COMPL 01/30/	ETED	
	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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPROPR	3 NATE	(X5) COMPLETION DATE	
	conference. 3.1-19(b)			completing work orders if an is identified. The Maintenance Director wo conduct Receptacle Facepla and Exposed Wire Audit we for 8 weeks, every other weeks and monthly for 8 weeks and monthly for 8 weeks and monthly for 8 weeks and monthly be corrected upon discovery. The findings will be reported Monthly QAPI Committee an any patterns are identified at monthly QAPI meeting an acceptant plan will be written by the committee. The action plan be monitored by the administ or designee monthly until resund substantial compliance in achieved 95% or greater.	vill te ekly ek for 8 eks, to the d if the etion will trator solved		
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are per kept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. Of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2.1.2. Based on record rev	elocation Plan plan for the protection of all heir evacuation in the event eriodically instructed and he their duties under the plan, plan is readily available erator or with security. The he basic response required 7.2.1.2 and provides for all helan components per 18.7.1.3, 18.7.2.1.2, height 19.7.1.1 through 19.7.1.3, height 2.2, 19.7.2.3 view and interview, the facility	K 0711	It is the practice of this facilit	y to	03/11/2024	
	failed to provide a c	complete facility specific	,, = 1	have a written plan for the	-		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 39 of 54

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155208	B. W	ING		01/30/2024	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	3			LAGRANGE RD		
HANOVE	ER NURSING CENT	ΓER			/ER, IN 47243		
(X4) ID	1	STATEMENT OF DEFICIENCIE	I	ID	T	(V5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	, and the second	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1110		plan for the protection of all			protection of all patients and t		
	residents to accurately address all life safety				evacuation in the event of an		
	systems, plus a system addressing all items				emergency.		
		101, 2012 edition, Section			No residents were negatively		
		2.2.2 requires a written health care			affected by the alleged deficie	nt	
		ty plan that shall provide for			practice.		
	the following:	1			On 2-20-24 the Disaster plan	was	
	(1) Use of alarms				updated to include the following		
	1 1	f alarm to fire department			the removal of equipment from	•	
	, ,	ne call to fire department			corridor in the event of an		
	(4) Response to ala	-			emergency and the staff response	onse	
	(5) Isolation of fire				to the activation of a battery		
	(6) Evacuation of immediate area				operated smoke alarm within	a	
	(7) Evacuation of si				resident room.		
	` '	loors and building for			This alleged deficient practice	has	
	evacuation	5			the potential to affect all		
	(9) Extinguishment	of fire			occupants in the event of an		
		states any required aisle or			emergency.		
		e less than 48 inches in clear			On 2-2-24 the Administrator		
		g as means of egress from			re-educated the Maintenance		
		oms. Projections into the			Director on the written plan for	r the	
		l be permitted for wheeled			protection of all residents and	I	
	_	the relocation of wheeled			their evacuation in the event of		
		fire or similar emergency is			emergency as outlined in NFF		
		itten fire safety plan and			101. All other staff in serviced		
		or the facility. The wheeled			this process by 2-26-26.		
	equipment is limite				This process will be monitored	d by	
	i. Equipment in use				the administrator during montl	- · · · · · · · · · · · · · · · · · · ·	
		ncy equipment not in use			drills and if issues are identifie	-	
	iii. Patient lift and t				re-educated will be completed		
		ice could affect all occupants			indicated.		
	in the event of an er	_			The findings will be reported to	o the	
		-			Monthly QAPI Committee and		
	Findings include:				any patterns are identified at t	I	
	_				monthly QAPI meeting an acti		
	Based on a review	of the facility's "Fire			plan will be written by the		
		n" on 01/30/24 between 9:45			committee. The action plan w	rill	
	•	with the Maintenance Director			be monitored by the administr	I	
	_	ated under "Duties of Staff			or designee monthly until reso		
		tmental Basis as Follows:" for			and substantial compliance is	I	

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 155208	A. BUILDING B. WING	01	COMPLETED 01/30/2024	
	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	
K 0712 SS=F Bldg. 01	oxygen carts, medicas time permits". The removal of equipevent of an emerger does not address state of a battery operated resident room. Based record review, the Macknowledged and a did not address the procorrectly. This finding was revand Maintenance Disconference. 3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include the alarm signal and should conditions. Fire drills and unexpected the conditions, at lease The staff is familial aware that drills are routine. Where dready 9:00 PM and 6:00 announcement manual ble alarms. 19.7.1.4 through 1 Based on record reversided to provide quarter of 3 shifts duries.	t quarterly on each shift. It with procedures and is the part of established sills are conducted between AM, a coded by be used instead of the same and interview, the facility parterly fire drill documentation on g 1 of 4 quarters. This would affect all residents, as well	K 0712	It is the practice of this facility conduct and document fire dril at least quarterly on each shift unexpected time under varying conditions. No residents were negatively	ls, at	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 41 of 54

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA I OF CORRECTION (IDENTIFICATION NUMBER) 155208	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/30/2024
	PROVIDER OR SUPPLIER ER NURSING CENTER	410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRI DEFICIENCY)	5.112
	Findings include: Based on review of the facility's fire drill reports on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters: a. Second shift (evening) of the first quarter (January, February, and March), third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2023. b. Third shift (night) of the first quarter (January, February, and March), second quarter (April, May, and June), third quarter (October, November, and December) of 2023. Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports and said no other fire drill reports could be located for the missing shifts and quarters of 2023. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		affected by this alleged defici practice. Fire drills will be completed quarterly on each shift and documented on the Fire Drill and will be completed at unexpected times. This alleged deficient practice the potential to affect all resid as well as staff and visitors in facility. On 2-2-24 the Maintenace Di was re-educated on NFPA 10 specifically related to the documentation requirements drills. The Administrator will audit the monthly documentation of all drills prior to the end of each month to ensure they are conducted on the correct shift to ensure staff are familiar with procedures and are aware the drills are part of the establishmoutine. The Fire Drill Docume will be kept by the Maintenan Director in the Life Safety Bin The findings will be reported Monthly QAPI Committee for months if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored the administrator or designed monthly until resolved and substantial compliance is achieved 100%.	Form e has lent, the rector 01; of fire ne fire t and th at ed ent(s) ce der. to the 6

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 42 of 54

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 01/30/2024				
	ROVIDER OR SUPPLIER R NURSING CENT		4	110 W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)	_	DATE
K 0741	NFPA 101						
SS=E	Smoking Regulation	ons					
Bldg. 01	Smoking Regulation	ons					
	Smoking regulatio	ns shall be adopted and					
	shall include not le	ess than the following					
	provisions:						
	(1) Smoking shall	be prohibited in any room,					
	ward, or compartn	nent where flammable					
	liquids, combustib	le gases, or oxygen is					
	used or stored and	d in any other hazardous					
		area shall be posted with					
	signs that read NO	SMOKING or shall be					
	posted with the int	ernational symbol for no					
	smoking.						
	• •	occupancies where					
	smoking is prohibi	_					
		d at all major entrances,					
	• •	vith language that prohibits					
	smoking shall not						
		tients classified as not					
	responsible shall b						
		nt of 18.7.4(3) shall not					
		atient is under direct					
	supervision.						
	• •	ncombustible material and					
		pe provided in all areas					
	where smoking is	rs with self-closing cover					
	• •	ashtrays can be emptied					
		ailable to all areas where					
	smoking is permitt						
	18.7.4, 19.7.4						
		on and interview, the facility	K 074	1	It is the practice of this facility t	0	03/11/2024
		arette butts were properly	12 0 / 1	•	follow the smoking regulations		03/11/2021
		2 area where cigarettes were			outlines in NFPA 101.	.=	
		ed by residents and staff. This			No residents were affected by	this	
		ould affect at least 10 residents			alleged deficient practice.		
	and staff.				On 1-30-24 the cigarette butts	in	
					the trash can were discarded,		
	Findings include:				louver cigarette metal ashtray		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QPJ121 Facility ID: 000115

If continuation sheet Page 43 of 54

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 01/30/2024	
	PROVIDER OR SUPPLIE ER NURSING CEN		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation p.m. and 5:30 p.m. the Maintenance Donoted: a. The Wing 3 Em 100 cigarette butts paper trash, further metal ashtray was an open ashtray with exposed. b. The Huntington within the courtyanthe trash can. Based on interview observation, the Macknowledged the paper trash in the tareas. This finding was re-	during a tour of the facility with birector, the following was aployee smoking area had over thrown in the trash can with amore, the louvered cigarette missing the louvers making it th over 50 cigarette butts. It's Unit resident smoking patio, and, had over 25 cigarette buts in wat the time of each anintenance Director cigarette butts mixed with rash cans at both smoking.		replaced with one that does in have missing louvers, located the smoking area on Wing 3. On 1-30-24 the cigarette butte the trash can were discarded located on the Huntington's L. All residents, staff and visitors have the potential to be affect by this alleged deficient pract. The Maintenance Director conducted rounds in all approximates were improperly disposed and ashtrays were inworking order. On 2-2-24 the Administrator re-educated the Maintenance Director on the NFPA 101; reto the Smoking Regulation. A other staff will be re-educated the smoketime the designated stresponsible for monitoring the disposal of cigarettes in the resident's smoking area and ensuring they are not dispose in the trash can, only the ash Additionally, the designed staresponsible for reporting if the ashtray is not in working orde. The Maintenace Director will conduct rounds 5 days a week weeks, weekly for 8 weeks, every other week for 8 weeks, every other week for 8 weeks, monthly going forward as part the Preventative Maintenance Program. The findings will be reported to Monthly QAPI Committee for	anot drin sin sin sin sin sin sin sin sin sin s

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet

Page 44 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	l í	JILDING	onstruction 01	(X3) DATE S COMPL 01/30/	ETED
	PROVIDER OR SUPPLIER			410 W L	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 LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0761 SS=F					months if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator monthly until resolved and substantial compliance is achieved 95% of greater.	У	
Bldg. 01	interview; the facili inspection and testin door assembly was LSC 19.1.1.4.1.1. (dividing fire barrier permitted only in compared to have a factor of the fa	on, record review, and ty failed to ensure an annual ng of 1 of 1 oxygen room fire completed in accordance with Communicating openings in s required by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings fire protection rating by Table feeted by approved, listed, semblies and fire window or accompanying hardware, s, closing devices, anchorage, fire with the requirements of for Fire Doors and Other s, except as otherwise de. NFPA 80 5.2.1 states fire fill be inspected and tested not and a written record of the signed and kept for inspection 80, 5.2.4.1 states fire door visually inspected from both overall condition of door	K 0	761	It is the practice of this facility ensure annual inspection of th oxygen transfilling room fire do assembly. No residents were affected by alleged deficient practice. All fire door assemblies locate within the facility will be inspectested, and documented by the facility contractor. This alleged deficient practice the potential to affect all reside as well as staff, and visitors. On 2-2-24 the Administrator re-educated the Maintenace Director on K761 and trained of inspecting and testing fire doo Audit results will be reviewed by the Monthly QAPI Committee of period of 12 months.	e boor this d cted, e had ent, on rs.	03/11/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 45 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		l í	UILDING	nstruction 01	(X3) DATE COMPL 01/30	LETED	
	PROVIDER OR SUPPLIEI			410 W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		tates as a minimum, the					
	following items sha	all be verified:					
	(1) No open holes of	or breaks exist in surfaces of					
	either the door or fi	rame.					
	(2) Glazing, vision	light frames, and glazing beads					
		rely 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						
	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,						
		apletely closes when operated					
	from the full open						
		is installed, the inactive leaf					
	closes before the ac						
		are operates and secures the					
	door when it is in the	-					
		vare items that interfere or					
	prohibit operation a	are not installed on the door or					
	frame.						
	` ′	fications to the door assembly					
		ed that void the label.					
	` '	edge seals, where required, are					
		their presence and integrity.					
	_	ice could affect all residents,					
	as well as staff, and	l visitors.					
	Findings include:						
	Based on record rev	view on 01/30/24 between 9:45					
		with the Maintenance Director					
	_	was unable to provide					
		an annual inspection of the					
		room fire door assembly.					
		at the time of record review,					
		irector said there was no					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 46 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		 ILDING	01	COMPL 01/30/	ETED	
	PROVIDER OR SUPPLIER ER NURSING CENT		410 W L	.ddress, city, state, zip cod .AGRANGE RD ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT 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)	TE	(X5) COMPLETION DATE
	documentation of ar oxygen transfilling of Based on observation with the Maintenand and 5:45 p.m., there room fire door asser	a annual inspection of the room fire door assembly. In annual inspection of the room fire door assembly. In a during a tour of the facility be Director between 2:00 p.m. In a was one oxygen transfilling be mbly noted in the facility. In a during the Administrator frector during the exit				
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and whe anesthesia is adminitial installation, respectively. Additional testing in defined by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, aless than or equal the LIM test switch activates both visual LIM circuits with all manual test is performed than or equal to 12 tested per 6.3.3.3. renovation to the execords are maintal associated repairs	a - Maintenance and beptacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. Is performed at intervals rented performance data. Is sted as hospital-grade at released at intervals not ths. Line isolation monitors are tested at intervals of to 1 month by actuating rented performance data. Is rested at intervals of to 1 month by actuating rente for a servicing, the rented at intervals less rented at intervals rented at interv				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 47 of 54

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2024		
	PROVIDER OR SUPPLIED			410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, 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)	TE	(X5) COMPLETION DATE
	interview; the facili documentation was nonhospital-grade or resident room locat NFPA 99, Health C Section 6.3.4.1.3 st hospital-grade, at p locations where decanesthesia is admin intervals not exceed Section 6.3.2.2, Re Rooms requires the receptacle shall be The continuity of the electrical receptacle polarity of the hot a each electrical receptacle receptacles) shall be ounces). This defic residents. Findings include: Based on record real.m. and 2:00 p.m. present, there was an annual resident to hospital-grade receptacle of the electrical receptacles. Findings include:	on, record review and ity failed to ensure complete available for all electrical receptacles in all ions tested at least annually. Care Facilities Code 2012 Edition, ates receptacles not listed as attent bed locations and in ep sedation or general istered, shall be tested at ding 12 months. Additionally, ceptacle Testing in Patient Care exphysical integrity of each confirmed by visual inspection. The grounding circuit in each exphasical integrity of each confirmed by visual inspection. The grounding circuit in each exphasical properties and neutral connections in ptacle shall be confirmed; and the grounding blade of each expect locking-type expected to the less than 115 grams (4 item) practice could affect all expected for the past 12 month expected for the past 12	K 0	914	It is the practice of this facility ensure complete documentatic available for all nonhospital-grelectrical receptacles in reside room locations are tested at leannually. No residents were negatively affected by this alleged deficie practice. The annual receptacles test we tested by 2-20-24 and any issuidentified will be corrected upodiscovery. On 2-2-24 the Administrator re-educated the Maintenance Director on NFPA 101 Electric Systems Maintenance and Testing specific to annually inspecting nonhospital-grade electrical receptacles in reside room locations and will continue monitored in accordance we NFPA standards. Any findings will be reported to monthly QAPI Committee for further review and if any patter are identified at the monthly Q meeting an action plan will be written by the committee. The action plan will be monitored be the administrator monthly until resolved and substantial compliance is achieved 95% of greater.	on is ade nt ast nt ill be ues on cal at the	03/11/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 48 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	, ,	JILDING	nstruction 01	(X3) DATE : COMPL 01/30/	ETED
	PROVIDER OR SUPPLIER			410 W L	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD 'ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	TE	(X5) COMPLETION DATE
	met with all pertiner 12 month period. B 2:00 p.m. and 5:45 p with the Maintenand four to six electrical room. This finding was rev	le Testing requirements was nt information within the past ased on observations between p.m. during a tour of the facility the Director, there were at least receptacles in each resident viewed with the Administrator frector during the exit					
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterior monthly test, a pro annually confirm th safety and critical and testing of the switches are perfo NFPA 110. Generator sets are exercised under lo year in 20-40 day once every 36 mor Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainter energy power sour accordance with N	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer fried in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inthe for 4 continuous hours. der load conditions include					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 49 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2024 155208 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD HANOVER NURSING CENTER HANOVER, IN 47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the K 0918 It is the practice of this facility to 03/11/2024 facility failed to maintain a complete written record maintain a complete written record of monthly generator load testing for 1 of 1 of monthly generator load testing. generator during 12 of the past 12 months. No residents were negatively Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires affected by this alleged deficient monthly testing of the generator serving the practice. emergency electrical system to be in accordance The Monthly Load Testing is part with NFPA 110, the Standard for Emergency and of the Preventative Maintenance Standby Powers Systems, Chapter 8. Chapter Program. 6.4.4.2 of NFPA 99 requires a written record of This alleged deficient practice inspection, performance, exercising period, and could potentially affect all repairs for the generator to be regularly residents, staff and visitors. maintained and available for inspection by the On 2-2-24 the Administrator authority having jurisdiction. Chapter 6-4.4.1.3 of re-educated the Maintenance 2012 NFPA 99 requires batteries for on-site Director on maintaining a generators shall be maintained in accordance with complete written record of monthly NFPA 110, 2010 Edition, Standard for Emergency load testing for the generator, in and Standby Power Systems. 8.3.7 requires accordance with NFPA 110, the storage batteries, including electrolyte levels or Standard for Emergency and battery voltage, used in connection with systems Standby Powers System, Chapter shall be inspected weekly and maintained in full 8. and on 2-23-24 the Regional compliance with manufacturer's specifications. Maintenance Director trained the 8.3.7.2 states defective batteries shall be repaired Maintenace Director how to or replaced immediately upon discovery of perform the load testing. defects. Chapter 6.5.4.2 of NFPA 99 requires a The administrator will review the written record of inspection, performance, monthly documentation for the exercising period, and repairs shall be regularly monthly generator load testing and maintained and available for inspection by the the required documentation, such

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 50 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2024			
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			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)	ATE	(X5) COMPLETION DATE	
	authority having jurpractice could affect visitors. Findings include: Based on review of testing reports on 0 2:00 p.m. with the latter was no month documentation avait September of 2023. There was monthly documentation for 0 2023, however, their transfer time, or am documented reports there was no cool d December 2023 reptime of record revies aid he has only been Maintenance Direct and was not able to of monthly load tes	the generator inspection and 1/30/24 between 9:45 a.m. and Maintenance Director present, ly generator load test lable for January through for the emergency generator.			as, the percentage of load, transfer time, or amperage readings on the documented reports. The findings will be reported to Monthly QAPI Committe for 1 months for further review and patterns are identified at the monthly QAPI meeting an act plan will be written by the committee. The action plan will be monitored by the administration monthly until resolved and substantial compliance is achieved 95% or greater.	o the 2 if any ion		
	and Maintenance D conference.	irector during the exit						
	facility failed to ensinspections for 1 of for 52 of 52 weeks. NFPA 99 requires be shall be maintained 2010 Edition, Stand Standby Power Sys	review and interview, the sure a written record of weekly 1 generator was maintained Chapter 6-4.4.1.3 of 2012 patteries for on-site generators in accordance with NFPA 110, lard for Emergency and tems. 8.3.7 requires storage electrolyte levels or battery						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 51 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/30/2024			
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER				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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE			
	inspected weekly at compliance with ma 8.3.7.2 states defect or replaced immedi defects. Chapter 6. written record of in exercising period, a maintained and ava authority having just practice could affect visitors. Findings include: Based on review of testing reports on 0 2:00 p.m. with the 1 there was no docume mergency generate for 52 of the past 52 the time of record r Director confirmed inspection/testing dereview. This finding was re	anection with systems shall be and maintained in full anufacturer's specifications. Eve batteries shall be repaired ately upon discovery of 5.4.2 of NFPA 99 requires a spection, performance, and repairs shall be regularly illable for inspection by the risdiction. This deficient at all residents, staff and an anufacture of the generator inspection and 1/30/24 between 9:45 a.m. and Maintenance Director present, mentation available to show the or was inspected/tested weekly 2 weeks. Based on interview at eview, the Maintenance there was no weekly ocumentation available for viewed with the Administrator irector during the exit								
K 0920 SS=E Bldg. 01	Extens Electrical Equipmonents Extension Cords Power strips in a pused for components	ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable ed electrical equipment								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121

Facility ID: 000115

If continuation sheet

Page 52 of 54

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			ETED	
155208		155208	B. WING 01			01/30/	01/30/2024	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					LAGRANGE RD			
HANOVER NURSING CENTER			HANOVER, IN 47243					
11/11/07/2	TIANOVER NORSING CENTER			1174100	LIX, IIN 47.243			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION DD FFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	, ,	les that have been						
		alified personnel and meet						
		10.2.3.6. Power strips in						
	1	cinity may not be used for						
	, -	, personal electronics),						
		m care resident rooms that						
		E. Power strips for PCREE						
		r UL 60601-1. Power strips						
		the patient care rooms						
	, ,	r) meet UL 1363. In						
	-	ooms, power strips meet						
		ls. All power strips are						
	_	precautions. Extension						
		d as a substitute for fixed						
	-	re. Extension cords used						
	temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.							
	· ·	9), 10.2.4 (NFPA 99), 400-8						
		(D) (NFPA 70), TIA 12-5	17.0	020	It is the practice of this facility	t-a	03/11/2024	
	Based on observation and interview, the facility failed to ensure power strips and multi-plug		K 0920	920	ensure power strips in patient		03/11/2024	
	_	sed as a substitute for fixed			vicinity are only used for	care		
	_	oke compartments. LSC 19.5.1			components of movable patient			
	_	-			care related electrical equipme			
	requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could				assembles that have been	>1 IL		
					assembled by qualified personnel.			
					No resident was affected by the	nis		
					alleged deficient practice.			
					On 1-30-24 the non-approved			
					power strip was removed from			
	affect over 20 resident, staff, and visitors. Findings include:				room 47.			
					On 1-30-24 the multi-plug adapter			
	<i>3</i>				was removed from room 40.			
	Based on observation	ons on 01/30/24 between 2:00			On 1-30-24 the multi-plug ada	pter		
		during a tour of the facility with			was removed from the	,		
		rector, the following was			maintenance office.			
	noted:				On 1-30-24 the multi-plug ada	pter		
		ing a non-approved power			was removed from Wing 1 Nui	-		
	Its all it, was asing a non approved power				l		I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QPJ121 Facility ID: 000115

If continuation sheet Page 53 of 54

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPLETED	
		155208	B. WING			01/30/2024	
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	SUMMARY: (EACH DEFICIEN REGULATORY OR strip with several ite small refrigerator. b. Room 40 was us plugged into a wall c. The Maintenance adapter plugged inte d. The Wing 1 Nur multi-plug adapter p Based on interview observation, the Ma acknowledged the u multi-plug adapters areas. This finding was re-	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ems plugged in including a ing a multi-plug adapter receptacle. e Office/Shop had a multi-plug to a wall receptacle. ses Station was using a plugged into a wall receptacle. at the time of each		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Station. This alleged deficient practice could potentially affect over 20 residents, staff, and visitors. On 2-2-24 the Administrator re-educated the Maintenance Director on the use of power of and extension cords outline in NFPA guidelines All other staff be re-educated by 2-26-24. The Maintenace Director will conduct Power Cords and Extension Cord Audits weekly 8 weeks, every other week for weeks and monthly for 8 week The audits will include a variet locations; resident room, storal areas, offices, common areas, bathrooms, nursing station; issidentified will be corrected upon discovery. The findings will be reported to Monthly QAPI Committe for 12 months for further review and patterns are identified at the monthly QAPI meeting an actiplan will be written by the committee. The action plan we be monitored by the administration of the plan will be written by the committee. The action plan we be monitored by the administration of the plan will resolved and substantial compliance is	for 8 ks. cy of age sues on the 2 if any on	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: QPJ121 Facility ID: 000115 If continuation sheet Page 54 of 54