STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	08/09/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00382302. Complaint IN00382302 - Substantiated. Federal/State deficiency related to the allegations is cited at F689. Survey date: August 9, 2022 Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census Bed Type: SNF/NF: 72 Residential: 7 Total: 79 Census Payor Type: Medicare: 29 Medicaid: 42 Other: 1 Total: 72 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 10, 2022.	F 0000	We are requesting paper compliance for this alleged deficiency .	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision was in place for a resident whom was at risk for choking with meals when not up in a specialized chair for 1 of 3 resident reviewed for accidents hazards. (Resident B) Findings include: The clinical record for Resident B was reviewed on 8/9/22 at 11:34 a.m. A Quarterly Minimum Data Set (MDS) assessment, dated 6/10/22, indicated the resident was moderately cognitively impaired and had adequate hearing and vision. The resident's speech was unclear, but he was usually understood and usually understood others. He required the extensive physicial assistance of two staff members for mobility and transfer; and extensive one staff member for eating. The diagnoses included, but were not limited to, COVID-19, acute respiratory failure with hypoxia, Huntington's disease, chorea (a neurological disorder characterized by jerky, involuntary movements), weakness, and seizures. A Care Plan, dated 2/9/21, indicated Resident B was at risk for an ADL self care performance deficit. Interventions included, but were not limited to, resident required staff participation to eat. A physician's order, dated 5/6/22, indicated the resident was to be up in a Broda (a tilt-in-space positioning chair) chair for meals and snacks; if the resident refused to get up, staff were to stay with the resident while the tray was present in the	F 0689	F 689 Free of Accident Hazards/Supervision/Devices It is the practice of this facility to maintain and follow the facilities Care Plan/Intervention policy. Resident B has no negative outcome from this alleged deficient practice. All residents with a care plan/intervention of staff supervision while eating could potentially be affected by this alleged deficient practice. A care plan audit of all residents who require supervision while eating will be audited and reviewed by the IDT team to ensure that the measures are appropriate and are in place. All nursing staff will be inserviced on 08/30/22 regarding the facilities care plan/intervention policy. CNA's will also be inserviced on cna pocket sheets. Any staff who fail to comply with the points of the inservice will be further educated. The DON/ADON or designee will monitor 3 residents daily with a care plan/intervention of staff supervision while eating x 4 weeks, weekly x 4 weeks, and monthly x 3. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action	09/08/2022

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	resident's room due to decreased safety awareness and increased risk of choking related to Huntington's disease and dysphagia. A Progress Note, dated 5/6/22 at 1:41 p.m., indicated the resident had a choking episode at lunch. When he coughed to clear, he vomited a moderate amount of undigested food. New orders were received for the resident to be up in a Broda chair at all meals unless staff were in the room at bedside. A Progress Note, dated 5/9/22 at 9:54 a.m., indicated a new physician's order was received to obtain an x-ray for Resident B related to aspiration due to a choking incident. During an observation and interview on 8/9/22 at 12:35 p.m., Certified Nursing Aide (CNA) 2 was wearing an N95 mask and a face shield. She donned a gown and gloves and delivered a meal tray to Resident B in his room. The resident was in isolation due to Covid. She asked if the resident wanted to eat lunch since he had no breakfast. CNA 2 then raised the head of the bed to approximately 45 degrees, placed a pillow behind the resident's back, and set the tray in front of him. She removed her gown and gloves, washed her hands, and left the room. CNA 2 did not ask the resident to get up into the Broda chair. The CNA indicated if staff needed to know a resident's interventions they could look at resident interventions in the computer or on the CNA pocket sheets. The CNA indicated she thought the resident could feed himself. During an interview on 8/9/22 at 12:43 p.m., RN 3 indicated if she needed to know what care plan interventions were in place for a resident, she would look in the chart or the physician's orders.		plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved. The Administrator or designee will monitor 3 CNA's daily x 4 weeks, weekly x 4, and monthly thereafter to ensure that they are following the resident interventions on their pocket sheets. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved. Date of Compliance: 09/08/22	

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	The RN read the physician's order, dated 5/6/22, for Resident B and the resident was to be monitored while eating if not up in his chair. She would monitor staff by checking their CNA pocket sheets to ensure they were following the resident's interventions. The RN observed the resident and confirmed he had a meal tray with no staff present in his room. A CNA pocket sheet was provided by RN 3, on 8/9/22 at 12:43 p.m., the sheet indicated Resident B was to be up for all meals; if he refused to get up, staff were to stay with him until he finished eating and the tray was removed from his room. During a telephone interview on 8/9/22 at 2:37 p.m., Speech Therapist 1 indicated Resident B should be at a 90 degree angle to eat. He was at a high risk for choking if he was not set up at 90 degrees. The current facility policy titled, " Care Plans - Comprehensive," with a revision date of September 2010 provided by the Administrator indicated, "An Individualized comprehensive care plan ...to meet the resident's medical, nursing, mental, and psychological needs ...3. F. identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and or functional levels ..." This Federal tag relates to Complaint IN00382302. 3.1-45(a)			