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	02/15/2017

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 8, 9, 10, 13, 14, and 15, 2017 Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census bed type: SNF/NF: 51 Total: 51 Census payor type: Medicare: 2 Medicaid: 43 Other: 6 Total: 51 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on February 19, 2017.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or			

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	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on record review, interview and observation, the facility failed to follow physicians' orders related to wound treatments and dental services. This deficient practiced effected 2 of 15 residents reviewed for documentation. (Residents 30 and 50) Findings include: 1. Resident 30's records were reviewed on 02/08/2017 at 3:01. The physician's order for wound care, dated 01/11/2017, indicated the staff were to cleanse areas on the right and left buttock with wound cleanser daily and apply mepilex sacral dressing daily and as needed if the dressing becomes soiled or dislodged until healed. The MAR (Medication Administration Records) were reviewed on 02/08/2017 at 3:35 P.M. The current medication administration treatment record, dated 03/15/2016, indicated to cleanse buttocks, apply Sure Prep No Sting and let dry, then apply sacral optifoam to	F 0157	F157 Requires the facility to follow physicians' orders related to wound treatments and dental services. 1. Resident 30's treatment order was clarified with the physician and order transcribed to the treatment record. Resident 50 had dental appointment scheduled. 2. All residents have the potential to be affected. All treatment orders are to be reviewed with the March rewrites to ensure all treatment orders are transcribed to the treatment record. All residents were reviewed to ensure dental appointments were scheduled. No concerns were noted. See below for corrective measures. 3. The Physician Orders policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure. 4. The DON or her designee will review all new physician orders to ensure treatment orders are added to the treatment record. The DON or her designee will utilize the	02/27/2017

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	buttocks, and change every three days and as needed for prevention. During an interview on 02/08/2017 at 3:42 P.M., the Corporate Nurse indicated the order dated 01/11/2017 did not get added to the MAR and a transcription error occurred. During an observation on 02/10/2017 6:54 A.M., staff provided pericare for Resident 30. The resident had three open areas on his buttocks that had bright red wound beds. Resident was transferred to his wheelchair following care. The quarterly MDS (Minimum Data Set) assessment, dated 10/29/2016, indicated Resident 30 was moderately cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 10. Diagnoses included, but were not limited to, dementia, stroke, hemiplegia or hemiparesis, renal insufficiency, and arthritis. The resident was able to make himself understood and understand others with no speech or hearing difficulties. The resident was totally dependent and needed the assistance of two staff members for bed mobility and transfers along with extensive assistance of two staff members for toilet use. The resident and had no unhealed pressure ulcers. 2. The Clinical Record for Resident 50 was		nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. The Social Service Director will conduct 5 interviews on residents a week ensuring residents are scheduled for dental visits as needed. These audits will be conducted weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted 5. The above corrective measures will be completed on or before February 27, 2017	

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	reviewed on 02/13/2017 at 11:35 A.M. A referral dated 10/12/2016 from the dental health care provider indicated the resident was to be referred to a general dentist or oral surgeon to extract all upper teeth and to X-ray, evaluate, and treat decay on lower teeth. After extractions and healing, the dental health care provider would make the resident an upper denture. Review of the nurse's note, dated 10/16/2016 at 3:45 P.M., indicated the resident was seen by the dentist and would like resident 50's top teeth extracted and the bottom teeth evaluated and treated. The resident was aware and had no questions or concerns. An appointment was to be made during business hours on 10/13/2016. The most recent annual MDS assessment, dated 10/27/2016, indicated Resident 50 had a BIMS of 12 and was moderately cognitively impaired. The resident required extensive assistance of two staff for personal hygiene, including oral care. The resident had ovbious cavities or broken natural teeth. Resident's active diagnoses include but were not limited to multiple sclerosis, coronary artery disease, peripheral vascular disease, anxiety, and depression. The current resident care plan, dated 11/10/2016 and updated 01/30/2017,			

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	indicated the resident required special attention for oral care related to obvious cavities and broken natural teeth. During an observation and interview on 02/08/2017 at 2:01 P.M., Resident 50 was observed to have obvious dental caries and missing teeth. He indicated that the facility was aware of this, but he wasn't satisfied with how they were handling things. He saw a dentist at the facility three months ago, and he was supposed to have an appointment to have his upper teeth pulled so he could get dentures. During an interview with RN (Registered Nurse) 3 on 02/15/2017 at 10:06 A.M., she indicated when a resident had an appointment it was written on the desk calendar for a follow up. It was also documented in the nursing notes, and if the appointment was scheduled out far enough, it would show up on the next month's MAR. During an interview on 02/15/2017 at 2:55 P.M., the DON (Director of Nursing) indicated an order or a referral for an outside service was to be handled by nursing. Nursing should have scheduled an appointment for Resident 30.			

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	The current facility policy titled "Physician Orders" and dated 10/2014 was provided by the Corporate Compliance Nurse on 02/14/2017 at 4:57 P.M. and was reviewed at that time. The policy indicated, "...Transcribe new order onto MAR or TAR, as indicated. Ensure any follow through is completed." 3.1-5(a)(3)			
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including			

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	the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the			

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	resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to include the resident's representative in care plan meetings based on 1 of 3 family interviews conducted. (Resident 21) Findings include: During an interview on 02/09/2017 at 12:20 P.M., resident 21's family member and legal guardian indicated she had not been called for a care plan meeting for over a year. Recently a nurse at the facility had text her cell phone telling her about the most recent care plan meeting, but she couldn't attend since she didn't have enough notice. During an interview on 02/13/2017 at 12:36 P.M., the Social Services Director indicated she doesn't always make notes	F 0280	F280 Requires the facility to include the resident's representative in care plan meetings. 1. Resident 21's family will be invited to attend the care plan meeting. 2. All residents have the potential to be affected. An audit was completed to ensure family members were invited to the care plans and concerns addressed if voiced. See below for corrective measures. 3. The Care Plan Meeting Protocol policy and procedure was reviewed with no changes made. (See attachment D) The staff was inserviced on the on the above procedure. 4. The Social Service Director along with the administrator will call	02/27/2017

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	of whom she talked to when calling and notifying families about upcoming care plan meetings. She thought a family member was present by phone for one care plan meeting but wasn't sure when it was or which family member it was. She normally kept a monthly calendar where she wrote down the family members names and phone numbers then disposed of the calendars each month. She had no way of looking back and reviewing them. Record review, on 02/13/2017 at 2:29 P.M., of the Interdisciplinary Care Plan Conference Record indicated the resident and responsible party were notified of care plan meetings that took place on 02/04/2016, 05/12/2016, and 01/19/2017 although it did not specify who was notified. There was no indication that anyone was notified of the care plan meetings that took place on 08/11/2016, 10/21/2016, and 02/02/2017. The current facility policy titled "Care Plan Meeting Protocol" and dated 10/2014 was provided by the Corporate Compliance Nurse, on 02/14/17 at 4:57 P.M., and was reviewed at that time. The policy indicated, "...The resident or family member(s)/legal representative will be invited to join the meeting." 3.1-35(c)(2)(C)		resident's responsible parties for care plan meetings that are on the schedule. The audits will be conducted weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure families are involved with care plan meetings. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before February 27, 2017.	

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F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review, interview and observation, the facility failed to prevent pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. (Residents 30) Findings include: 1. Resident 30's records were reviewed on 02/08/2017 at 3:01 P.M. The physician's order for wound care, dated 01/11/2017, indicated the staff were to cleanse areas on the right and left buttock with wound cleanser daily and apply	F 0314	F314 Requires the facility to prevent pressure ulcers. 1. Resident 30's pressure ulcer on left buttocks is healed. The pressure ulcer on the right buttocks is almost healed. 2. All residents have the potential to be affected. All resident's treatment orders were reviewed to ensure the orders are transcribed on the treatment record. See below for corrective measures. 3. The Pressure Ulcer Prevention	02/27/2017

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	mepilex sacral dressing daily and as needed if the dressing becomes soiled or dislodged until healed. The "Weekly Skin Assessment", dated 01/08/2017, indicated Resident 30 had no skin alterations and skin was intact. The Medication Records for Resident 30's treatments were reviewed on 02/08/2017 at 3:35 P.M. The record indicated the current treatment, ordered on 03/15/2016, was cleanse buttocks, apply Sure Prep No Sting, let dry, apply sacral optifoam to buttocks, and change every three days and as needed for prevention. Two "Initial Pressure Ulcer Assessment" forms, dated 02/08/2017 and provided by the DON on 02/08/2017 at 4:12 P.M., indicated the resident had a stage two pressure area on his left buttock measuring 0.2 x 0.2 centimeters with a depth of less than 0.1 and a stage two pressure area on his right buttock measuring 0.3 x 0.2 centimeters with a depth of less than 0.1 that were developed after admission. The bathing records, dated 12/19/2016 through 02/09/2017, were completed by the staff who provided the care and signed by a nurse. The records indicated		policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the on the above procedure. 4. The DON or her designee will review all new physician orders to ensure treatment orders are added to the treatment record. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before February 27, 2017.	

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	the resident's skin was intact with no skin issues from 12/19/2016 through 02/09/2017. The "Pressure Ulcer Risk" care plan was dated 05/10/2016 and was last updated on 02/07/2017. The interventions included, but were not limited to, "Encourage and assist resident with turning and repositioning at least every two hours and as needed." There was no care plan for pressure ulcers in the clinical record on or before 02/08/2017 at 4:12 P.M. The CNA (Certified Nursing Assistant) Assignment Sheet was provided by the Corporate Nurse, on 02/15/2017 at 10:10 A.M. and reviewed at that time. The assignment sheet provides the CNAs with information regarding the care each resident required. The sheet did not indicate Resident 30 was to be turned and/or repositioned every two hours. The quarterly MDS (Minimum Data Set) assessment, dated 10/29/2016, indicated the resident was moderately cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 10. Diagnoses included, but were not limited to, dementia, stroke, hemiplegia or hemiparesis, renal insufficiency, and arthritis. The resident was totally			

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	dependent and needed the assistance of two staff members for bed mobility and transfers, needed extensive assistance of two staff members for toilet use, and had no unhealed pressure ulcers. During an interview on 02/08/2017 at 3:01 P.M., the DON indicated an "Initial Pressure Ulcer Assessment" form should have been completed when the skin issue was noted and kept with the weekly skin assessment sheet. The DON performed the assessment and completed the documentation at that time. During an interview on 02/09/2017 at 10:26 A.M., RN (Registered Nurse) 2 indicated Resident 30's skin issues were from shearing. His backside would heal then open up again because the CNAs were "not good" about lifting the resident up when they repositioned him. The resident had requested to be moved to his recliner from his wheelchair and the RN was waiting on another staff member to help move him. During an observation and interview, on 02/09/2017 at 10:45 A.M., Resident 30 was in his room in his wheelchair with a hoyer lift harness under him and a pressure reducing cushion under the hoyer harness.			

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HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

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	During an observation and interview on 02/09/2017 at 12:06 P.M., Resident 30 remained in his wheelchair. He indicated staff had told him they would help him get into his recliner. During an observation on 02/09/2017 at 12:33 P.M., Resident 30 continued to sit in his wheelchair in his room. During an anonymous interview, staff indicated Resident 30 was not currently on the two hour turn schedule nor had he been for the last six months, according to the CNA Assignment sheets. During an interview on 02/10/2017 at 8:12 A.M., NA (Nursing Assistant) 4 indicated she monitored residents' skin during showers, care, assisting with meals, and anytime she was in their presence. She reported any abnormalities to the nurse. During an interview on 02/15/2017 at 10:03 A.M., the Compliance Nurse indicated nursing measures for residents with a stage two pressure ulcer or shearing included the use of a non-pressure mattress, ensure resident was turned at least every 2 hours, using a pressure relieving cushion on chairs, and if the skin issue was extreme the resident would be ordered a special bed. Every			

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	resident had a weekly skin assessment completed by a licensed nurse. Skin sheets were completed by the CNAs when showering / bathing residents. If a skin issue arose, the CNAs reported it immediately to the nurse and the nurse assessed it at that time. If the nurse observed a skin issue, she would initiate a skin sheet for either a pressure or a non-pressure wound, document the issue, and notify the physician for an order. Pressure areas are reviewed everyday. Once a week the skin nurse would measure the area, reassess, and fax the information to the Corporate Nurse During an interview on 02/15/2017 at 3:58 P.M., the DON indicated the CNAs are made aware of which residents are unable to reposition themselves and need assistance through the CNA assignment sheets. During an observation on 02/10/2017 at 6:54 A.M., staff provided pericare for Resident 30. The resident had three open areas on his buttocks that had bright red wound beds. The resident was transferred to his wheelchair following care. The current "Pressure Ulcer Prevention" policy, dated 10/2014, was provided by the Compliance Nurse and reviewed at			

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	that time. The policy indicated, "...Personnel will identify those residents most likely to experience skin breakdown, and take precautions necessary to prevent breakdown...Reposition resident approximately every two hours...Inspect skin for redness/open areas during provision of daily care..." 3.1-40(a)(1)			
F 0371 SS=E Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by			

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	family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview and record review, the facility failed to serve and store food in a sanitary manner related to food handling for 1 of 2 dining rooms and undated and expired food in 2 of 3 snack refrigerators. This had the potential to affect 43 of 51 residents who reside in wing 2 and received snacks from the refrigerators in wings 2 and 3. Findings include: 1. During a dining observation of wing 2, on 02/08/2017 at 12:28 P.M., the following was observed: CNA (Certified Nursing Assistant) 6 used hand sanitizer, touched Resident 26's bread with bare hands, folded it in half, used hand sanitizer, touched Resident 49's bread with bare hands, buttered and folded it in half, used hand sanitizer, touched Resident 56's bread with bare hands, then buttered the bread. 2. During an observation of the snack and nourishment refrigerator on wing three, conducted with the Corporate Nurse on 02/14/2017 at 10:25 A.M., the following was observed: The freezer did not contain a thermometer and contained an unlabelled hot pocket sandwich and four popsicles covered in frost. The	F 0371	F371 Requires the facility to serve and store food in a sanitary manner. 1. Staff was inserviced on how to properly serve food in the dining room. The nourishment refrigerators were immediately cleaned and all undated and expired food was discarded. 2. All residents have the potential to be affected. Staff inservice was conducted on handling food in the dining room. All refrigerators were cleaned and food items dated to ensure no expired food is present. See below for corrective measures. 3. The Glove Use and Meal Service policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the on the above procedure. 4. The DON or her designee will monitor one meal service ensuring staff is handling food properly and sanitary. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See	02/27/2017

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	refrigerator contained an open can of Hormel chili, with a clear cup covering the top, that did not have an opened date, an unlabeled plastic bag with two slices of cheese, three yogurt containers with expiration dates of 02/12/2017, two cartons of 2% milk with expiration dates of 02/11/2017 and 02/12/2017, and one carton of non-fat chocolate milk with an expiration date of 02/10/2017. During an interview on 02/14/2017 at 10:25 A.M., the Corporate Nurse indicated there should be nothing expired or unlabeled in the snack refrigerators. 3. During an observation of the snack and nourishment refrigerator on wing two, conducted with LPN (Licensed Practical Nurse) 5 on 02/14/2017 at 10:55 A.M., the following was observed: The refrigerator contained three yogurt containers with expiration dates of 02/12/2017, a tub of butter that expired on 01/2017, a container of soup with a resident's name on it dated 02/08/2017, and a clear plastic bag of cheese slices labeled "opened on 01/25/2017 and use by 2/03/2017". During an interview on 02/14/2017 at 10:55 A.M., LPN 5 indicated food brought in for residents from home should be labeled with a date received		attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. The Dietary Supervisor or her designee will conduct rounds to ensure all nourishment refrigerators are cleaned, food is not expired and all food items are dated. The Administrator or designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment G) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before February 27, 2017.	

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	and should be used within three days or thrown away. All food in snack refrigerators should be labeled and any expired food should be thrown away by staff. The current facility policy titled "...Glove Use and Meal Service" dated 11/2014, was provided by the Corporate Nurse on 02/14/2017 at 4:54 P.M. and was reviewed at that time. The policy indicated, "...Employees may not touch ready-to-eat foods with bare hands, gloves must be worn." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0412 SS=D Bldg. 00	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested,			

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	assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview, and record review, the facility failed to provide outpatient dental services for one of two residents reviewed for dental services. (Resident 50) Findings include: During an observation and interview on 02/08/2017 at 2:01 P.M., Resident 50 was observed to have obvious dental caries and missing teeth. He indicated that the facility was aware of this, but he wasn't satisfied with how they were handling things. He saw a dentist at the facility three months ago and he was supposed to have an appointment to have his upper teeth pulled so he could get dentures. The most recent annual MDS (Minimum Data Set) assessment, dated 10/27/2016, indicated Resident 50 had a BIMS (Brief Interview for Mental Status) of 12 and	F 0412	F412 Requires the facility to provide outpatient dental services. 1. Resident #50 has dental appointment scheduled. 2. All residents have the potential to be affected. All residents were reviewed to ensure dental appointments were scheduled. No concerns were noted. See below for corrective measures. 3. The Nursing Center Admission and Payment Agreement policy and procedure was reviewed with no changes made. (See attachment H) The staff was inserviced on the on the above procedure. 4. The Social Service Director will conduct 5 interviews on residents a week ensuring residents are scheduled for dental visits as needed. These audits will be conducted weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained	02/27/2017

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	was moderately cognitively impaired. The resident required extensive assistance of two staff for personal hygiene, including oral care, and had obvious cavities or broken natural teeth. Resident 50's active diagnoses included but were not limited to multiple sclerosis, coronary artery disease, peripheral vascular disease, anxiety, and depression. The current resident care plan dated 11/10/2016 and updated 01/30/2017 indicated the resident required special attention for oral care related to obvious cavities and broken natural teeth. The Clinical Record was reviewed on 02/13/2017 at 11:35 A.M. A referral dated 10/12/2016 from the contracted dental provider indicated the resident was to be referred to a general dentist or oral surgeon to extract all upper teeth and to X-ray, evaluate, and treat decay on lower teeth. After extractions and healing the contracted dental provider would make the resident an upper denture. Review of the nurse's note, dated 10/16/2016 at 3:45 P.M., indicated Resident 50 was seen by the dentist and the dentist would like the resident's top teeth extracted and the bottom teeth evaluated and treated. The resident was aware and had no questions or concerns.		and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted 5. The above corrective measures will be completed on or before February 27, 2017.	

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	An appointment was to be made during business hours on 10/13/2016. During an interview with the Social Services Director, on 02/13/2017 at 12:24 P.M., she indicated Resident 50 saw the dentist that used to provide contract services for the facility in October of 2016. The contracted dental provider service had changed, and the resident would be seen again in March 2017 by a different provider. When asked about the referral and sending the resident out for tooth extraction, she indicated his dental services would be provided in the facility. During an interview with RN (Registered Nurse) 3 on 02/15/2017 at 10:06 A.M., she indicated when a resident had an appointment it was written on the desk calendar for follow up. It was also documented in the nursing notes and, if the appointment was scheduled out far enough, it would show up on the next month's MAR (Medication Administration Record). During an interview on 02/15/2017 at 2:32 P.M., the Social Services Director indicated she arranged for contracted services in the facility and that it was up to nursing staff to facilitate appointments that were to be made outside of the			

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	facility. During an interview on 02/15/2017 at 2:55 P.M., the DON (Director of Nursing) indicated the Social Services Director handled referrals for services that would take place in the facility including, but not limited to, dental or podiatry. An order or a referral for an outside service was to be handled by nursing. Since the dental referral for Resident 50 was for an outside service, nursing should have scheduled an appointment. The current facility document titled "...Nursing Center Admission and Payment Agreement" and dated for 03/2015 was provided on 02/14/2017 at 10:45 A.M. by the Business Office Manager and was reviewed at that time. The policy indicated, "...the Facility agrees to provide the Resident with room and board, nursing care and services..." 3.1-24(b)			
F 0465 SS=E Bldg. 00	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			

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	(h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation and interview the facility failed to provide a safe and functional environment for the residents and the public as evidence by the loose hand rails in the hall ways. This had the potential to effect 42 of 51 residents in the facility who were independently mobile. Findings include: During the initial tour, on 02/08/2017 at 10:45 A.M., the following hand rails were noted to be loose: - outside room 57 - between rooms 54 and 53 - between the fire door and the main dining room - between the main dining room and the exit door - outside room 51 - outside room 44 - between rooms 41 and 42 - between rooms 26 and 25 During an interview, on 02/14/2017 at 2:09 P.M., the Maintenance Supervisor (MS) indicated he was unaware of the	F 0465	F465 Requires the facility to provide a safe and functional environment for the residents and the public. 1. Handrails that were indentified were fixed immediately. 2. All residents have the potential to be affected. All handrails in the facility were assessed to ensure the handrail was securely fastened to the wall. No concerns were noted. See below for corrective measures. 3. The Maintenance Director was inserviced on the need to ensure handrails are securely fastened to the wall for safety. 4. The Maintenance Supervisor will conduct rounds ensuring that the handrails are securely fastened to the wall. These audits will be conducted weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment I) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted	02/27/2017

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	hand rails being loose. When anything was in need of repair staff were to complete a maintenance request form and put it in his designated box. 3.1-19(f)		5. The above corrective measures will be completed on or before February 27, 2017.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1)At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and	F 9999	F9999 Requires the facility to ensure each employee had appropriate tuberculin testing. 1. Employee TB test was given per the guidance . 2. All employees have the potential to be affected. A complete audit was conducted ensuring the state guidance on Mantoux testing was followed. No concerns were noted. See below for corrective measures. 3. The Human Resource Officer was inserviced on the proper way to track Mantoux testing in the facility. (Employee TB Screening) (Attachment J) 4. The Human Resource Director will track all new hires to ensure their TB screening is conducted per state guidance. These audits will be conducted weekly times four weeks, then every two weeks times two	02/27/2017

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	nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) moths, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each employee had appropriate tuberculin testing. This affected 1 of 10 staff members reviewed for employee records. (Social Service Director) Findings include: The Employee PPD (Purified Protein Deriative) form for the SSD (Social Service Director) was provided by the OM (Office Manager), on 02/13/2017 at 11:54 A.M., and was reviewed at that time. The form indicated the second step of the SSD's initial PPD was given on 01/18/2016 and read on 01/20/2016. The SSD's most recent tuberculin testing had been given on 01/27/2017 and read on		months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment K) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted 5. The above corrective measures will be completed on or before February 27, 2017.	

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	01/30/2017. During an interview on 02/13/2017 at 2:56 P.M., the BOM (Business Office Manager) indicated the SSD was working between the dates of 01/20/2017 and 01/27/2017. During an interview on 02/13/2017 at 3:07 P.M., with the DON (Director of Nursing), She indicated the OM keeps a book or calendar and notifies her when the employees' PPDs are due. During an interview on 02/13/2017 at 3:31 P.M., the OM indicated she was the one who keeps track of when employees' PPDs are due. She said the SSD was salary and the salary personals' hire date doesn't always show up, therefore the SSD was missed for a week. The current facility policy, titled "Employee TB Screening" and dated 10/2015, was provided by the corporate compliance nurse on 02/14/2017 at 4:44 P.M. and was reviewed at that time. The policy indicated, "...The frequency of repeat tuberculin skin testing will depend on the risk of infection with tuberculosis, but no less than annually thereafter."			

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HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 8 Sample: 7 Hanover Health and Rehabilitation was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	