STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000115	A. BUILDING: _____ B. WING _____	C 08/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00235892. This visit included the Investigation of a Nursing Home Complaint IN00236780. Complaint IN00235892 - Substantiated no deficiencies related to the allegations are cited. Complaint IN00236780 - Substantiated no deficiencies related to the allegations are cited. Survey date: August 15, 2017 Facility number: 000115 Residential Census: 8 Hanover Nursing Center was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00235892.	R 000		