STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Hanover	410 W Lagrange Rd Hanover, IN 47243

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38239 Based on interview, record review, and observation, the facility failed to ensure a resident's rights were honored related to their personal possessions for 1 of 3 residents reviewed for resident rights. (Resident E) Findings include: On 07/12/24 at 2:11 P.M., a Complainant indicated the facility had COVID-19 in the building. Resident E was moved to a different room so that her room could be used for a COVID-19 resident. Resident E was not able to take all of her belongings to the new room and she was upset. During an interview on 07/18/24 at 12:17 P.M., the DON (Director of Nursing) indicated the facility had to temporarily move some residents to different rooms due to COVID-19. Resident E had been in a room without a roommate. They moved her down the hall to a room with another female resident and moved a male resident (Resident J) that had been exposed to COVID-19 (his roommate tested positive) into her room. They moved several of Resident E's belongings into the new room but left non-essential items in her previous room. If the resident needed anything from her old room, a staff member could get it for her. Resident J was bedbound, and he wouldn't be able to go through Resident E's personal items. It was a temporary move, they told Resident E it would be for about a week. After a few days, Resident E became upset about the room change. The resident had been non-compliant with care in the past, but her behaviors escalated with the room change. The resident was ultimately sent out to an inpatient psychiatric facility. Resident E's clinical record was reviewed on 07/18/24 at 1:30 P.M. A Significant change MDS (Minimum Data Set) assessment, dated 04/17/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, hypertension, diabetes, arthritis, and depression. Resident E's previous room was observed with CNA (Certified Nurse Aide) 2 on 07/18/24 at 2:26 P.M. Resident E's belongings left in the room included, but were not limited, to the following items: - various wall hangings including a hand drawn canvas of a dog, - a closet full of clothes on hangers with several pairs of shoes on the floor, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- a large cabinet with glass doors. Various snacks, including an opened loaf of bread, and [NAME]-knacks/collectibles were stored inside and on top of the cabinet, - a pile of items on the floor in front of the cabinet that included pillows, blankets, clothing, and an empty box, and, - a mother's memorial board on the floor near the cabinet, with a pair of glasses laying on top of it. During an interview on 07/18/24 at 2:30 P.M., CNA 2 indicated she was familiar with Resident E. Initially, the resident was supposed to move into the room right next door to her old room and she was agreeable to that. Something changed and she ended up going down the hallway to a different room. The current facility policy titled Resident Rights, with a revision date of 03/08/2017, was provided by the Assistant Director of Nursing on 07/18/24 at 3:28 P.M. The policy indicated, .resident rights .included the resident's right to .retain and use personal possessions to the maximum extent that space and safety permit . This citation relates to Complaint IN00438629. 3.1-9(a)