

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Hanover		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>50498</p> <p>Based on record review and interview, the facility failed to ensure a resident who displayed psychosocial adjustment difficulties and a history of trauma received appropriate treatment to attain the highest practicable mental well-being for 1 of 3 residents reviewed for psychosocial services.(Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 09/04/24 at 11:50 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/15/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, renal insufficiency, diabetes, anxiety, and depression. The resident received dialysis.</p> <p>A progress note, dated 06/28/24 at 6:03 A.M., indicated Resident C was slamming his bedroom door out of anger. When it was explained that his roommate was trying to sleep, he stated A da*n train won't wake him up.</p> <p>A progress note, dated 06/28/24 at 12:13 P.M., indicated Social Services would make referrals to mental health services for Resident C.</p> <p>A progress note, dated 06/29/24 at 7:33 P.M., indicated Resident C was in his doorway when another resident attempted to enter. After a verbal disagreement Resident C was grabbed by the hair. Staff intervened and separated the residents and placed the residents on one-on-one (one staff to one resident) observation.</p> <p>A progress note, dated 06/30/24 at 12:16 P.M., indicated Social Services spoke with Resident C regarding the incident that occurred. The resident reported that he was attacked and did not fight back but did try to keep the other resident from pulling his dialysis port out.</p> <p>A psychosocial assessment, dated 07/01/24 at 09:26 A.M., indicated Resident C had a history of recreational drug use. The resident attempted suicide two years prior.</p> <p>(continued on next page)</p>

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
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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 08/01/24 at 2:00 A.M., indicated a CNA (Certified Nurse Aide) reported that Resident C told her he was going to choke his roommate. Upon staff questioning Resident C, he stated his roommate had nightmares every night and made a bunch of noise that kept him up. When told he could not make threats towards others, Resident C stated, Well put me in my own room then and continued to voice frustration. Staff monitored the residents by leaving the residents' door open.</p> <p>A progress note, dated 08/23/24 at 6:33 P.M., indicated Resident C was upset with nursing staff because he couldn't have his medications yet. When it was explained that he would receive the medications at 7:00 P.M. Resident C stated, you are both fu**ing wh*res and slammed his door. When nursing staff went to explain that his medications were not due until 7:00 P.M. the resident stated, whatever.</p> <p>During an interview on 09/04/24 at 3:07 P.M., LPN (Licensed Practical Nurse) 4 indicated Resident C had a few outbursts and would refuse dialysis at times. A few weeks prior during morning meeting when the door was closed staff could hear him screaming in the hallway. He stated the ride service they used to transport him to and from dialysis had left him, and he then refused to go to dialysis if he had to ride with them. He was very explosive. She had never seen anyone behave that way over having to use a ride service.</p> <p>During an interview on 09/04/24 at 3:04 P.M., QMA (Qualified Medication Aide) 5 indicated when Resident C wanted his pain medications, he would circle the desk.</p> <p>During an interview on 09/04/24 at 2:52 P.M., the Administrator indicated she was aware of Resident C expressing frustration. Resident C cursed when he would get angry. She was not sure why he didn't see psych (psychiatric) services.</p> <p>During an interview on 09/04/24 at 12:34 P.M., the DON (Director of Nursing) indicated Resident C had some behaviors with ups and downs. He was explosive, but nothing directed at other residents just staff.</p> <p>During an interview on 09/04/24 at 3:29 P.M., the Social Services Director indicated Resident C would be grumpy sometimes. He told nursing staff that he would strangle another resident once but then said he was expressing frustration and that he wasn't going to actually hurt anybody. The behavior would be an indication that he would need psychiatric services, but Resident C had never received those services.</p> <p>A care plan, dated 06/25/24, titled Trauma informed care included, but was not limited to, an intervention, with a start date of 06/25/24, for the resident to receive psychiatry/psychology services as needed.</p> <p>The current facility policy titled, Behavioral Health Services (previously Behavior Management Program), dated 11/28/12, was provided by the Administrator on 09/04/24 at 3:55 P.M The policy indicated, .to ensure that each resident receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being .</p> <p>This Citation relates to Complaint IN00442016</p> <p>3.1-43(a)(1)</p>		