

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 09/09/2020
NAME OF PROVIDER OF SUPPLIER HANOVER NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on record review and interview, the facility failed to complete Coronavirus Screening Logs and temperature assessments related to monitoring for COVID-19 for 5 of 5 residents reviewed Residents B, C, D, E, and F) and 10 of 60 days reviewed for infection control prevention. Findings include: 1. The facility's 2020 Resident Coronavirus Screening Logs were reviewed on 09/09/20 at 11:50 A.M. The Screening Logs documentation included, but were not limited to, resident names, temperature, cough, sore throat, and shortness of breath, for every resident every shift. The facility lacked the following documentation: - The July 25, 2020 Resident Coronavirus Log could not be provided. - The August 2020 Resident Coronavirus Log lacked documentation for the following dates: 08/04/20, 08/12/20, 08/13/20, 08/15/20, 08/17/20, 08/21/20, 08/22/20, 08/23/20, and 08/25/20. During an interview on 09/09/20 at 2:39 P.M., LPN (Licensed Practical Nurse) 2, indicated the residents were monitored for symptoms of COVID every shift by having their temperatures taken and for other symptoms out of the ordinary. The residents' temperatures were documented on the screening logs and she would not document them anywhere else in the clinical record. The forms would then be given to the Director of Nursing. The clinical records for Residents B, C, D, E, and F lacked documentation of temperatures or monitored for COVID symptoms for 08/04/20, 08/12/20, 08/13/20, 08/15/20, 08/17/20, 08/21/20, 08/22/20, 08/23/20, and 08/25/20. a. The clinical record for Resident B was reviewed on 09/08/20 at 11:30 A.M. The resident's [DIAGNOSES REDACTED]. An Admission MDS (Minimum Data Set) assessment, dated 05/29/20, indicated the resident's cognition was moderately impaired. b. The clinical record for Resident C was reviewed on 09/08/20 at 11:30 A.M. The resident's [DIAGNOSES REDACTED]. An Admission MDS assessment, dated 07/31/20, indicated the resident's cognition was severely impaired. c. The clinical record for Resident D was reviewed on 09/09/20 at 9:50 A.M. The resident's [DIAGNOSES REDACTED], [MEDICAL CONDITION], anxiety, [MEDICAL CONDITIONS], and severe intellectual disabilities. A Quarterly MDS assessment, dated 08/15/20, indicated the resident was cognitively intact. d. The clinical record for Resident E was reviewed on 09/09/20 at 3:30 P.M. The resident's [DIAGNOSES REDACTED]. A Quarterly MDS assessment, dated 05/30/20, indicated the resident was cognitively intact. e. The clinical record for Resident F was reviewed on 09/09/20 at 3:30 P.M. The resident's [DIAGNOSES REDACTED]. A Quarterly MDS assessment, dated 08/17/20, indicated the resident was cognitively intact. During an interview on 09/09/20 at 4:58 P.M., the Administrator indicated the monitoring should have been completed and could not be provided. The facility followed the CDC (Centers for Disease Control and Prevention) guidance related to COVID-19 monitoring. The facility did not have a policy regarding COVID-19 monitoring. 3.1-18(b)(1)(A)</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.