

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155730	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2013
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NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN 47031
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: December 3, 4, 9, 10, 11, 12 and 13, 2013</p> <p>Facility number: 000420 Provider number: 155730 AIM number: 100266230</p> <p>Survey team: Jennifer Carr, RN, TC Diana Sidell, RN Sunny Jungclaus, RN Julie Dover, RN</p> <p>Census bed type: SNF/NF: 90 Residential: 13 Total: 103</p> <p>Census payor type: Medicare: 13 Medicaid: 63 Other: 27 Total: 103</p> <p>Residential sample: 6 Supplemental sample: 2</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000		
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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.

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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review, observation, and interview the facility failed to ensure residents were free from verbal abuse for 2 of 3 residents reviewed for abuse. (Residents #11 and #84)</p> <p>Findings include:</p> <p>1. On 12/12/13 at 4:18 p.m., the Director of Nurses (DoN) provided a fax transmittal of an allegation of abuse, dated 12/7/13. A brief description of the incident indicated: "It was brought to my attention at 1:50 am this morning that RN# 1 had said something inappropriate about a resident while in residents room. RN, 2 CNAs, and 2 EMTs were in residents room transferring resident from stretcher to bed. This incident apparently occurred previously - RN # 1 was not on duty on 12/7/13. Type of injury/injuries: None. Immediate Action Taken: Nurse suspended</p>	F000223	F223 It is the intent of Ripley Crossing to ensure that all residents are free from verbal abuse. Corrective action taken for Residents #11 & #84: The allegation of verbal abuse was thoroughly investigated and reported to the Indiana State Department of Health. Other residents with the potential to be affected: No other residents have the potential to be affected due to termination of perpetrators involved. Allegations of abuse were thoroughly investigated and reported to the Indiana State Department of Health. Measures to prevent reoccurrence: All staff will be in-serviced by 1/13/2014 on the definition of verbal abuse and immediate reporting to the administrator or designee. Monitoring of Corrective Action to ensure the practice will not reoccur. The Abuse Coordinator will complete a summary monthly and present to monthly QA Committee related to incidents of verbal abuse and finding of investigation. The date systematic changes will be completed and	01/13/2014	

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	<p>pending investigation."</p> <p>The follow up and investigation of the allegation of abuse was provided by the DoN on 12/12/13 at 4:40 p.m. The investigation indicated statements from CNA #2, CNA #3, EMT #6 and EMT #7. CNA #2 and CNA #3 indicated on the early morning of 11/23/13, RN #1 had stated Resident #11 was a "f*****g fat a**", when RN #1, CNA #2, CNA #3, EMT #6 and EMT #7 were positioning Resident #11 in bed. Statements from EMT #6 and EMT #7 verified that RN #1 had made this statement. The outcome of the investigation was "The two CNAs counseled and reprimanded due to failure to report timely. Abuse inservices will be given to all staff on 12-20-13. [RN #1] discharged from facility."</p> <p>During an interview, on 12/13/13 at 11:07 a.m., the Administrator indicated RN #1 was terminated for that reason.</p> <p>Resident #11's record was reviewed on 12/13/13, at 9:44 p.m. The record indicated Resident #11 was admitted with diagnoses that included, but were not limited to, weakness, hypothyroidism, sleep apnea, coronary artery disease, high blood</p>		<p>who is responsible: 1/13/2014 The Abuse Coordinator/designee will be responsible for ongoing compliance.</p>				

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	<p>fats, delirium, adrenal insufficiency, obesity, dementia, high blood pressure, decreased bowel motility, urinary retention, and osteoarthritis.</p> <p>Nurse's notes, dated 11/23/13 at 3:00 a.m., indicated: "Returned from [local hospital emergency room] per [name of] ambulance on stretcher, accompanied by res' daughter [daughter's name]. T 97.7, P. 88, R 20 and easy, BP 153/91. Breath sounds clear throughout. No distress. Put in bed & [raised] HOB. Skin color good. O2 sat 96% on RA (room air). Has new script for Levaquin 500 mg po daily X10 days, to start tomorrow. Siderails [up]. Daughter [with] resident."</p> <p>No documentation in the Nurse's notes indicated Resident #11 had behaviors, was agitated, or complained of pain or discomfort.</p> <p>Social service notes, dated 12/9/13, indicated: "SW (Social Worker) received a phone call @ home on 12/7/13 re: incident reported. Incident happened [night of] 11/22/13. SW spoke [with] Res - Res had [no] recollection. Res had experienced [no] change in her mood or behavior over the last few weeks. SW spoke [with] DTR (daughter) [name of</p>						

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	<p>daughter] at length today. DTR does not believe Res was aware of incident. Offered reassurance to DTR that reports made to appropriate agencies & situation is being taken seriously & problem addressed. DTR appreciative."</p> <p>On 12/12/13 at 5:00 p.m., Resident #11 was laying in her bed, her daughter was present and indicated she had had a medical procedure and had to lay flat. Resident #11 was able to speak clearly when approached, said she was doing well and was pleasant and smiling.</p> <p>2. Resident #84's record was reviewed on 12/13/13 at 11:25 a.m. The record indicated Resident #84 was admitted with diagnoses that included, but were not limited to, organic mood disorder, hypokalemia, dementia, mania, dementia with behavior disturbance, gastro-esophageal reflux disorder, and bipolar.</p> <p>Social service notes dated 11/25/13 indicated: "SW (Social Worker) received call @ home on 11/24/13 re: incident [with] CNA. Per nurse - Res was not aware of what was said. [No] emotional changes. SW visited Res</p>				

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	<p>today - Res responses were non-sensical noises. Res is usual self. SW called son & notified him of incident on 11/24/13. Son expressed appreciation for the call."</p> <p>During an observation on 12/13/13 at 11:34 a.m., Resident #84 was observed seated at a table in the dining room waiting for the noon meal to be served. She was dressed in street clothes and was very calm as she look around and watched others. Did not speak as others approached.</p> <p>A fax transmittal was provided by the Director of Nurses on 12/13/13 at 10:26 a.m. The fax/incident report indicated "...Incident Date 11/24/13 at 1:30 pm...Description of incident: Staff overheard [CNA #4] tell [Resident #84] to "shut up" and "I have had enough." Nurse intervened, counseled CNA [#4] and sent [CNA #4] home. Nurse notified Abuse Coordinator who then notified DON And Administrator. Type of Injury/Injuries: No apparent. Immediate Action Taken: Nurse intervened, counseled CNA and sent home. CNA suspended pending investigation."</p> <p>The follow-up report and investigation indicated: "Brief description of</p>				

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	<p>Incident: Staff overheard [CNA #4] yelling at [Resident #84]. After investigation, witnesses stated that CNA yelled at resident "[name of resident], I can't take it anymore." Nurse intervened and offered CNA a break CNA stated "no, I'm ok at least I got her to shut up." Nurse then intervened again by counseling and sent home for remainder of shift. As CNA was leaving wing, witnesses stated [CNA #4] cursed in front of residents. Nurse notified Abuse Coordinator who then notified DoN and Administrator. Type of Injuries: None. Immediate Action Taken: Nurse intervened, counseled CNA, sent CNA home and suspended pending investigation. APS (Adult protective services), ombudsman and local police notified. Preventative Measures Taken: [CNA #4] discharged."</p> <p>The investigation included a written statement from LPN #8, dated 11/24/13, that indicated, but was not limited to, "...Resident #84 was yelling out and [CNA #4] yelled at her "[name] stop"...[Resident #94] started yelling again. [CNA #4] yelled at her again. Not sure what her exact words were. She either said Shut-up or I got her to shut up...."</p>			
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	<p>A written statement from CNA #9, dated 11/24/13, indicated, but was not limited to, "It was about noon on Sunday and the residents were eating lunch. We were sitting at the feed table assisting residents with lunch. [CNA #4] was feeding [Resident #84] lunch. [Resident #84] then starting (sic) yelling her usual. [CNA #4] then yelled at [Resident #84] in her face. "Doris I can't take it anymore". [LPN #8] then told her "It does not do any good to yell at her" and asked [CNA #4] if she needed a break, [CNA #4] replied "No I am ok at least I got her to shut up." [CNA #4] at this point had yelled at [Resident #84] twice...later while I was brushing [Resident #84's] teeth I herd (sic) the door slam open bouncing off the wall. [CNA #4] then screamed "They are fu****g sending me home this is fu****g bulls**t I didn't do anything wrong." She then started crying. I [CNA #9] then told her she needed to leave she could not act like that in front of [Resident #84]. She then slammed the door and left."</p> <p>A "Counseling Report" form was filled out by LPN #8 on 11/24/13. The Report form indicated, but not limited to, a check mark on the line for "Abusive or threatening language or behavior (yelling at Resident). Other,</p>						

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	<p>please specify: CNA was asked if she needed to take a break, she stated "No" "I'm ok". She yelled at [Resident #84] 2-times...[Resident #84] was never left alone [with] [CNA #4]."</p> <p>During an interview, on 12/13/13 at 11:07 a.m., the Administrator indicated CNA #4 was terminated for that reason.</p> <p>A document titled "Abuse Prohibition Policy and Procedure", with a last review date of 4/17/2013, was provided by the Administrator on 12/12/13 at 4:46 p.m. The policy indicated, but was not limited to: "Policy: Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion...Verbal abuse: Refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe resident regardless of their age, ability to comprehend or disability...Reporting Procedure: 1. Any staff member</p>						

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	<p>witnessing an incident of physical, verbal, mental or sexual abuse, must intervene immediately on behalf of the resident. 2. After the resident's immediate safety is ensured, the staff member must then report the incident to the nurse in charge. The charge nurse reports the incident to the Administrator (or D.O.N. in his absence.) Procedures and reporting requirements for the nurse in charge are detailed in the file at the nursing station titled "Abuse Prohibition". 3. A thorough investigation is initiated of the allegations to gather pertinent information and verify the occurrence. 4. There must be appropriate steps taken to prevent further (potential) abuse while the investigation is in progress. 5. If the suspected abusive individual is an employee, it is the responsibility of the staff member in charge of the facility to suspend the abusive employee until the incident can be fully investigated...10. All incidents of resident abuse will be reported to the Indiana State Department of Health and any other agencies determined by the Administrator within 5 working days of the verification of the abuse...."</p> <p>3.1-27(b)</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	F225 It is the intent of Ripley	01/13/2014			

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	<p>Based on record review and interview, the facility failed to ensure an allegation of abuse was immediately reported to a charge nurse, the Administrator, and to the State Agency, and further failed to protect the resident between the alleged occurrence and the investigation that was begun after the reporting, which was 14 days later. This affected 1 of 3 residents reviewed for abuse who met the criteria for abuse. (Resident #11)</p> <p>Findings include:</p> <p>On 12/12/13 at 4:18 p.m., the Director of Nurses (DoN) provided a fax transmittal of an allegation of abuse, dated 12/7/13. A brief description of the incident indicated: "It was brought to my attention at 1:50 am this morning that RN# 1 had said something inappropriate about a resident while in residents room. RN, 2 CNAs, and 2 EMTs were in residents room transferring resident from stretcher to bed. This incident apparently occurred previously - RN # 1 was not on duty on 12/7/13. Type of injury/injuries: None. Immediate Action Taken: Nurse suspended pending investigation."</p> <p>The follow up and investigation of the</p>		<p>Crossing to ensure that all allegations of abuse are immediately reported. Corrective Action cannot be taken to correct the allegations of reporting to the state in a timely manner to address the situation of involving Residents # 11 & #84 but all staff will be in-serviced by 1-13-14 on the importance of reporting any suspicions of abuse to the charge nurse or supervisor immediately. Charge nurses or supervisors will then immediately report the incident to the Administrator, D.O.N. or Designee. A report of all allegations of Verbal Abuse will be sent to the Indiana State Department of Health, A.P.S., Ombudsman, Local Police as well as the attending physician and the resident's representative as per reporting guidelines. If the suspected perpetrator is an employee, he or she, will be immediately suspended until the investigation has been completed to protect all other residents. The Administrator or Designee shall ensure an investigation is done timely and effectively. Results of the investigation shall be reported to Indiana State Department of Health, A.P.S., Ombudsman, Local Police as well as the attending physician and the resident's representative as per reporting guidelines. If the investigation substantiates by the facility the involved employee shall be subject to immediate termination. Monitoring of</p>				

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	<p>allegation of abuse was provided by the DoN on 12/12/13 at 4:40 p.m. The investigation indicated statements from CNA #2, CNA #3, EMT #6 and EMT #7. CNA #2 and CNA #3 indicated on the early morning of 11/23/13, RN #1 had stated Resident #11 was a "f*****g fat a**", when RN #1, CNA #2, CNA #3, EMT #6 and EMT #7 were positioning Resident #11 in bed. Statements from EMT #6 and EMT #7 verified that RN #1 had made this statement. The outcome of the investigation was "The two CNAs counseled and reprimanded due to failure to report timely. Abuse inservices will be given to all staff on 12-20-13. [RN #1] discharged from facility."</p> <p>During an interview, on 12/13/13 at 11:07 a.m., the Administrator indicated RN #1 was terminated for that reason.</p> <p>Social service notes, dated 12/9/13, indicated: "SW (Social Worker) received a phone call @ home on 12/7/13 re: incident reported. Incident happened [night of] 11/22/13. SW spoke [with] Res - Res had [no] recollection. Res had experienced [no] change in her mood or behavior over the last few weeks. SW spoke [with] DTR (daughter) [name of</p>		<p>Corrective Action to ensure practice does not reoccur: The Abuse Coordinator will complete a summary monthly and present to monthly QA Committee related to incidents of verbal abuse and finding of investigation. The date systematic changes will be completed and who is responsible: 1/13/2014.</p> <p>The Abuse Coordinator/designee will be responsible for ongoing compliance.</p>				

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NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN 47031
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	<p>daughter] at length today. DTR does not believe Res was aware of incident. Offered reassurance to DTR that reports made to appropriate agencies & situation is being taken seriously & problem addressed. DTR appreciative."</p> <p>A document titled "Abuse Prohibition Policy and Procedure", with a last review date of 4/17/2013, was provided by the Administrator, on 12/12/13 at 4:46 p.m. The policy indicated, but was not limited to: "Policy: Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion...Verbal abuse: Refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe resident regardless of their age, ability to comprehend or disability...Reporting Procedure: 1. Any staff member witnessing an incident of physical, verbal, mental or sexual abuse, must intervene immediately on behalf of the resident. 2. After the resident's</p>			

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	<p>immediate safety is ensured, the staff member must then report the incident to the nurse in charge. The charge nurse reports the incident to the Administrator (or D.O.N. in his absence.) Procedures and reporting requirements for the nurse in charge are detailed in the file at the nursing station titled "Abuse Prohibition". 3. A thorough investigation is initiated of the allegations to gather pertinent information and verify the occurrence. 4. There must be appropriate steps taken to prevent further (potential) abuse while the investigation is in progress. 5. If the suspected abusive individual is an employee, it is the responsibility of the staff member in charge of the facility to suspend the abusive employee until the incident can be fully investigated...10. All incidents of resident abuse will be reported to the Indiana State Department of Health and any other agencies determined by the Administrator within 5 working days of the verification of the abuse...."</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement their policy for abuse in that one allegation of verbal abuse was not reported timely to a charge nurse, the Administrator, and the State Agency. This affected 1 of 3 residents reviewed for abuse for 3 residents who met the criteria for abuse. (Resident #11)</p> <p>Findings include:</p> <p>On 12/12/13 at 4:18 p.m., the Director of Nurses (DoN) provided a fax transmittal of an allegation of abuse, dated 12/7/13. A brief description of the incident indicated: "It was brought to my attention at 1:50 am this morning that RN# 1 had said something inappropriate about a resident while in residents room. RN, 2 CNAs, and 2 EMTs were in residents room transferring resident from stretcher to bed. This incident apparently occurred previously - RN # 1 was not on duty on 12/7/13. Type</p>	F000226	<p>F226 It is the intent of Ripley Crossing to implement our facilities' policy and procedure to thoroughly investigate and report all allegations of abuse. No other residents have the potential to be affected due to the perpetrator has been terminated. Measures to prevent occurrence: All staff will be in-serviced by 1-13-14 on the policy for abuse. Monitoring of Corrective Action to ensure the practice does not reoccur: The Abuse Coordinator will complete a summary monthly and present to monthly QA Committee related to incidents of verbal abuse and finding of investigation. The date systematic changes will be completed and who is responsible: 1/13/2014 The Abuse Coordinator/designee will be responsible for ongoing compliance.</p>	01/13/2014	

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	<p>of injury/injuries: None. Immediate Action Taken: Nurse suspended pending investigation."</p> <p>The follow up and investigation of the allegation of abuse was provided by the DoN on 12/12/13 at 4:40 p.m. The investigation indicated statements from CNA #2, CNA #3, EMT #6 and EMT #7. CNA #2 and CNA #3 indicated on the early morning of 11/23/13, RN #1 had stated Resident #11 was a "f*****g fat a**", when RN #1, CNA #2, CNA #3, EMT #6 and EMT #7 were positioning Resident #11 in bed. Statements from EMT #6 and EMT #7 verified that RN #1 had made this statement. The outcome of the investigation was "The two CNAs counseled and reprimanded due to failure to report timely. Abuse inservices will be given to all staff on 12-20-13. [RN #1] discharged from facility."</p> <p>During an interview, on 12/13/13 at 11:07 a.m., the Administrator indicated RN #1 was terminated for that reason.</p> <p>A document titled "Abuse Prohibition Policy and Procedure", with a last review date of 4/17/2013, was provided by the Administrator on 12/12/13 at 4:46 p.m. The policy</p>				

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	<p>indicated, but was not limited to: "Policy: Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion...Verbal abuse: Refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe resident regardless of their age, ability to comprehend or disability...Reporting Procedure: 1. Any staff member witnessing an incident of physical, verbal, mental or sexual abuse, must intervene immediately on behalf of the resident. 2. After the resident's immediate safety is ensured, the staff member must then report the incident to the nurse in charge. The charge nurse reports the incident to the Administrator (or D.O.N. in his absence.) Procedures and reporting requirements for the nurse in charge are detailed in the file at the nursing station titled "Abuse Prohibition". 3. A thorough investigation is initiated of the allegations to gather pertinent information and verify the occurrence. 4. There must be appropriate steps</p>			

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	<p>taken to prevent further (potential) abuse while the investigation is in progress. 5. If the suspected abusive individual is an employee, it is the responsibility of the staff member in charge of the facility to suspend the abusive employee until the incident can be fully investigated...10. All incidents of resident abuse will be reported to the Indiana State Department of Health and any other agencies determined by the Administrator within 5 working days of the verification of the abuse...."</p> <p>3.1-28(a)</p>			

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F000257 SS=D	<p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS</p> <p>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>Based on observation, interview and record review, the facility failed to maintain comfortable temperature levels in a resident's room for 1 of 35 residents reviewed for comfortable room temperatures. (Resident #71)</p> <p>Findings include:</p> <p>Resident #71's record was reviewed on 12/11/13 at 2:15 p.m. She was originally admitted to the rehabilitation unit of the facility on 7/29/13, following an in-patient hospital stay with the goal of discharge to home. Diagnoses included, but were not limited to, near syncope, weakness, hypertension, and depression.</p> <p>The resident's most recent Minimum Data Set (MDS) assessment, dated 11/3/13, included a Brief Interview for Mental Status (BIMS), which indicated that Resident #71's attention, orientation, and ability to register and recall new information was intact. The MDS "Social Service Progress Note", dated 11/3/13, indicated the following:</p>	F000257	<p>F257 It is the intent of Ripley Crossing to maintain room temperatures at a comfortable and safe level. Corrective action taken: Resident #71 has been offered to transfer to another room in the facility. To ensure no other residents are affected, an audit of all resident room temperatures will be done x1 by 1/13/2014. Monitoring of Corrective Action: Social Service director or designee will monitor all residents who have complaints of room temperature weekly x4, then monthly x4. Social Service director or designee will complete a monthly summary room temperature audit to be presented to the QA committee. Measures to prevent reoccurrence: Social Service director will be in-serviced by 1/13/2014 on monitoring rooms of all residents who have complaints of uncomfortable room temperatures for comfortable and safe temperatures to be in a range of 71 to 81 degrees. The date systematic changes will be completed and who is responsible: 1/13/2014. Social Service or designee.</p>	01/13/2014			

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	<p>1. "Res (resident) is understood by others. Speech is clear. Able to express wants and needs." 2. "Res (resident) is able to understand others with ease."</p> <p>A social services progress note, dated 9/6/13, indicated, "Placement will now be long-term D/T (due to) family unable to care for Res (resident) at home." A social services note, dated 11/14/13, indicated, "Trying to accommodate Res and family to move Res (resident) to Wing 1...." Another social service note, dated 11/20/13, indicated, "Housekeeping will be able to move Res (resident) on 11/22/13." No further social service notes were documented following this entry.</p> <p>Nursing notes, dated 11/22/13, indicated, "Res (resident) moved from Wing 4 to room 106-B. Res (resident) smiling and pleasant - states "I will get used to it."</p> <p>During an interview on 12/3/13 at 4:56 p.m., Resident #71 indicated that temperature levels in her room were uncomfortable. She indicated that her roommate keeps the temperature much cooler than she would like and that she is always cold. Res was</p>						

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	<p>observed sitting in her recliner wearing multiple layers of clothing, including a sweater. The privacy curtain was pulled and the heating unit was noted to be on the other side of the room. Resident #71 was wrapped in a flannel blanket pulled up to her chin and up over her ears. She became tearful and indicated, "I know I will spend the rest of my days here, but it's just so uncomfortable...I don't want to be a complainer." During multiple observations on 12/3/13, 12/4/13, 12/10/13, 12/11/13 and 12/12/13, Resident #71 was observed dressed in multiple layers of clothing and wrapped in a blanket. The privacy curtain was also observed to be pulled across the room, with a gap approximately 1 foot long between the wall and the curtain.</p> <p>Resident #71 was interviewed again on 12/12/13 at 2:20 p.m. She indicated, "It's freezing over here...I keep that curtain pulled (pointing to the privacy curtain pulled across the room) because it's the only way the heat comes through." When asked if anyone from social services had checked on her since her room change 11/22/13, she replied, "No."</p> <p>During an interview with the Director of Social Services (DSS) on 12/11/13</p>			

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	<p>at 2:34 p.m., she indicated that the resident began complaining of uncomfortable noise and temperature levels "just in the last few days." She further indicated, "We just came up with a plan yesterday. We are in the process of talking to families about room changes..."(Resident #71) is very hard to make happy anyway, but we keep trying."</p> <p>An environmental tour was conducted with the Administrator and the Maintenance Director on 12/12/13 at 2:45 p.m. They indicated that there is no way for residents to individually control the heat in their rooms. For residents on the side of the room without the heater, the Administrator indicated, "We tell them to pull the curtain and leave a little on each side to increase the heat flow." She further indicated that social services is responsible for addressing any concerns identified regarding resident comfort. Social servies is also responsible for checking on residents following a room change to see how they are adjusting.</p> <p>During an interview on 12/12/13 at 4:20 p.m., the DSS indicated that she usually checks in with the resident, family and staff the day of, or day after, a room change. She indicated</p>			

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	<p>that she did check on Resident #71 following her room change on 11/22/13 and that no concerns were identified. She confirmed that there was no social services documentation since 11/20/13, two days prior to Resident #71's room change on 11/22/13.</p> <p>3.1-19(h)</p>				

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F000258 SS=D	<p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on observation, interview and record review, the facility failed to maintain comfortable sound levels in a resident's room for 1 of 35 residents reviewed for comfortable sound levels. (Resident #71)</p> <p>Findings include:</p> <p>Resident #71's record was reviewed on 12/11/13 at 2:15 p.m. She was originally admitted to the rehabilitation unit of the facility on 7/29/13, following an in-patient hospital stay with the goal of discharge to home. Diagnoses included, but were not limited to, near syncope, weakness, hypertension and depression.</p> <p>The resident's most recent Minimum Data Set (MDS) assessment, dated 11/3/13, included a Brief Interview for Mental Status (BIMS), which indicated that Resident #71's attention, orientation, and ability to register and recall new information was intact. An MDS "Social Service Progress Note", dated 11/3/13, indicated the following:</p> <p>1. "Hearing is moderately impaired with hearing aids."</p>	F000258	<p>F 258 It is the intent of Ripley Crossing to maintain comfortable sound levels in the resident's rooms. Corrective action taken: Resident #71 has been offered to transfer to another room in the facility to remove from hearing range of her room-mate's TV. To ensure no other residents are affected, an audit of all resident room sound levels will be done by 1/13/2014. Monitoring of Corrective Action: Social Service director or designee will monitor all residents who have complaints of noisy room sound level weekly x4, then monthly x4. Social Service director or designee will complete a monthly summary audit to be presented to the QA committee. Measures to prevent reoccurrence: Social Service director will be in-serviced by 1/13/2014 on monitoring rooms of all residents who have complaints of noisy room sound levels for comfortable noise levels. The date systematic changes will be completed and who is responsible: 1/13/2014. Social Service or designee.</p>	01/13/2014	

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	<p>2. "Res (resident) is understood by others. Speech is clear. Able to express wants and needs." 3. "Res (resident) is able to understand others with ease."</p> <p>During an interview with the Administrator on 12/3/13 at 11:20 a.m., she provided a map of the facility, which indicated that residents were placed in wings 1 through 4 according to the degree of cognitive impairment as follows:</p> <p>Wing 1: "early" Wing 2: "mid" Wing 3: "intermediate" Wing 4: "late"</p> <p>A social services progress note, dated 9/6/13, indicated, "Placement will now be long-term D/T (due to) family unable to care for Res (resident) at home." Another social services note, dated 11/5/13, indicated, "Spoke with Res (resident's) DTR (daughter) re: long-term care. Rm (room) available on Wing 4. Discussed room change. DTR (daughter) gave consent but still wants her on waiting list for Wing 1...Will move Res on 11/7/13."</p> <p>The record indicated that Resident #71 was moved to wing 4 on 11/7/13. A social service progress note, dated</p>			

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	<p>11/14/13, indicated, "Trying to accommodate Res (resident) and family to move Res (resident) to Wing 1...." Another social service note, dated 11/20/13, indicated, "Housekeeping will be able to move Res (resident) on 11/22/13." No further social service notes were documented following this entry.</p> <p>Nursing notes, dated 11/22/13, indicated, "Res moved from Wing 4 to room 106-B. Res smiling and pleasant - states 'I will get used to it.'"</p> <p>During an interview on 12/3/13 at 4:56 p.m., Resident #71 indicated that the sound level in her room was uncomfortable as a result of the high volume of her roommate's television, which remained on constantly throughout the day. She indicated that she had informed the nursing staff of her discomfort and that her roommate was repeatedly asked to turn down the volume of her television, but always immediately turned it back up. Resident #71 became tearful and indicated, "I know I will spend the rest of my days here, but it's just so uncomfortable...I don't want to be a complainer." The volume of the television was observed to be very loud and easily audible from outside the room and throughout</p>			

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NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN 47031
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	<p>the wing during multiple observations on 12/3/13, 12/4/13, 12/10/13, 12/11/13 and 12/12/13. At no time was Resident #71's television observed to be on.</p> <p>RN #5 was interviewed on 12/11/13 at 2:15 p.m. She indicated that Resident #71 has complained about the noise level in her room and indicated, "I know it's a problem...The TV is loud. I turn it down a lot, but she (the roommate) turns it back up." She further indicated, "They may be considering a room change to someone more suitable.", but was not sure if social services had been contacted. She confirmed that social services would be responsible for facilitating a room change.</p> <p>During an interview with the Director of Social Services (DSS) on 12/11/13 at 2:34 p.m., she indicated that the resident began complaining of uncomfortable noise and temperature levels "just in the last few days." She further indicated, "We just came up with a plan yesterday. We are in the process of talking to families about room changes..."(Resident #71) is very hard to make happy anyway, but we keep trying."</p> <p>Resident #71 was interviewed again</p>			

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	<p>on 12/12/13 at 2:20 p.m. Upon greeting her, she indicated, "Hold on. Let me put my ears in." She was observed to remove 2 hearing aids from a black plastic box on the table beside her recliner and place one in each ear. She indicated, "I set [sic] with my ears out most of the time it's so loud." She further indicated, "I just was never a TV person...The 6:30 news, Wheel of Fortune, and Jeopardy is the only time I use my TV at all. I have to turn it up so loud to hear it...then they come in to tell me to turn it down." When asked if anyone from social services had checked on her since her room change on 11/22/13, she replied, "No."</p> <p>The television of Resident #71's roommate was observed to be so loud that it could easily be heard from the opposite end of the wing.</p> <p>During the environmental tour with the Administrator and the Maintenance Director on 12/12/13 at 2:45 p.m., the Administrator indicated that social services is responsible for addressing any concerns identified regarding resident comfort. Social services is also responsible for checking on residents following a room change to see how they are adjusting.</p>						

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	<p>During an interview on 12/12/13 at 4:20 p.m., the DSS indicated that she usually checks in with the resident, family, and staff the day of, or day after, a room change. She indicated that she did check on Resident #71 following her room change on 11/22/13 and that no concerns were identified. She confirmed that there was no social services documentation since 11/20/13, two days prior to Resident #71's room change on 11/22/13.</p> <p>3.1-19(f)</p>			
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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from falls for 1 of 4 residents who fit the criteria for falls. (Resident #129)</p> <p>Findings include:</p> <p>Resident #129's record was reviewed on 12/10/13 at 2:50 p.m. The record indicated Resident #129 was admitted with diagnoses that included, but were not limited to, presumed pneumonia, chronic obstructive pulmonary disease, weakness, depression, lung cancer, throat cancer, prostate cancer, high blood fats, gastro-esophageal reflux disease, congestive heart failure, high blood pressure, and anxiety.</p> <p>A fall risk assessment, dated 11/25/13, indicated resident's total score was 7, whereas a total score of 10 or higher was a high risk.</p>	F000323	<p>F 323 It is the intent of Ripley Crossing to prevent accidents by providing an environment that is free from hazards over which the facility has control. Corrective action taken for Res. #129: Care plan reviewed and a new intervention was implemented for each incident. Other resident's with potential to be affected: All residents who have falls. Monitoring of corrective action to ensure the practice will not reoccur: All falls will be investigated and a new intervention will be added to the care plan. A new acute care plan form has been implemented to capture the new interventions. Measures to prevent reoccurrence: Nurses will be in-serviced by 1/13/2014 on implementation and documentation of new fall interventions using the new acute care plan form. The date systematic changes will be completed and who is responsible: 1/13/2014. DON or designee.</p>	01/13/2014	

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	<p>A fall risk assessment dated 11/26/13 indicated a total score of 9, due to a fall on 11/25/13 at 7:40 p.m.</p> <p>A Skilled Nursing Assessment and data collection document, dated 11/25/13 at 7:40 p.m., indicated: "Res (resident) found on floor beside closet. When asked what happened, res replied, "I was trying to get my shirt on." Neuro checks started for unwitnessed fall...[no] injury noted. Res assisted to recliner. Encouraged res to use call light for assistance."</p> <p>A Care plan with a problem/need of "Fall" was initiated on 11/25/13. The goal/target date was "No further falls X 1 month." The Approaches were: Investigate for cause of fall & eval[uate] for injury. Notify therapy of falls. Give safety reminders as needed - (I.E. lock wheels, wear shoes, use call light. Make sure call light is in place. Notify MD & family of fall. TX (treatment) per MD order. Encourage use of call light." (Added on 11/25/13)</p> <p>The new intervention to "encourage use of call light" had already been included in the care plan and no new interventions were added to help prevent further falls.</p>						

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	<p>An "Incident Documentation and Investigation Tool" was provided by the Administrator on 12/11/13 at 12:14 a.m. The document indicated, but was not limited to, Resident #129 had a fall on 11/25/13 at 7:40 p.m. The resident had fallen in his room, and had been trying to put on his shirt. The resident stated "I was just trying to put my shirt on." This was an unwitnessed incident. Res was found sitting on the floor. The intervention was to encourage the resident to use the call light for help. The resident was on the Physical Therapy workload at the time of the fall also.</p> <p>A fall risk assessment dated 12/6/13 indicated a total score of 13, due to a fall on 12/6/13 at 12:15 a.m.</p> <p>A "Skilled Nursing Assessment and Data Collection", dated 12/5/13 at 8:00 p.m., indicated: "Res awake in recliner. A&O (alert and oriented) X3. Temp up to 100.2 & pulse up to 104. Resp quick & shallow [with] wheezes to bil[ateral] lower lobes. Has a cough that is productive. Awaiting culture results of sputum sent out this a.m. Wears O2 (oxygen) @ 3L O2 sats (saturation level) 95% this p.m. Abd (abdomen) soft & nontender. BS (+) X 4 quad. Ambulates [with] RW</p>				

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	<p>(rolling walker) gate slow & steady. Denies any pain @ this time. Call light in reach."</p> <p>A "Skilled Nursing Assessment and Data Collection", dated 12/6/13 at 12:15 a.m., indicated: "Res noted on floor in front of recliner. Res stated "trying to get to the bathroom to empty urinal." Res did press the call light for us to come to his room. I immediately checked on and assessed the resident and checked vs...st (skin tear) to (L) elbow 0.5 cm (centimeter) x 0.5 cm, (L) hand 2 cm X 1 cm, and (R) buttocks 5 cm X 0.5 cm. (L) hand st applied 2x2 dry drsg [with] telfa adhesive. (R) buttocks applied 4x4 dry drsg. No additional bruising noted. Res A&O X3. ROM (range of motion) intact. Did c/o (complain of) (R) hip pain. Gave PRN (as needed) tylenol per MD order. Pupils equally reactive. Did give Br (breathing) tx (treatment) d/t (due to) low O2 sat.</p> <p>An "Incident Documentation and Investigation Tool", dated 12/6/13, was provided by the Administrator on 12/11/13 at 12:14 a.m. The document indicated, but was not limited to, Resident #129 had a fall on 12/6/13 at 12:15 a.m. The resident was found sitting/lying on the</p>			

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	<p>bedroom floor in front of his recliner, pressing the call light. The resident said he was "trying to go to bathroom to empty the urinal." The new intervention was to apply non slip shoes.</p> <p>A Care plan with a problem need of "Fall" was initiated on 12/6/13. The goal/target date was "No further falls." (No target date written on the care plan.) The Approaches were: "Investigate for cause of fall & eval[uate] for injury. Notify therapy of falls. Give safety reminders as needed - (I.E. lock wheels, wear shoes, use call light. Make sure call light is in place. Notify MD & family of fall. TX per MD order."</p> <p>The care plan as written failed to include any new interventions to prevent further falls. On 12/12/13 at 3:45 p.m., the MDS coordinator indicated the care plan dated 11/25/13 was the original care plan put in place after the first fall and indicated "maybe the person who updated the care plan didn't see the intervention about the call light was already on the care plan."</p> <p>When queried on 12/12/13 at 4:00 p.m., with ADON said the care plan intervention added to the 11/25/13</p>			

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	<p>care plan was not a new intervention, and the care plan did not get updated for the 12/6/13 fall.</p> <p>A policy and procedure for "Accident/Incident Report and Investigation", with a revised date of 5/23/13, was provided by the Assistant Director of Nursing on 12/12/13 at 3:40 p.m. The policy indicated, but was not limited to, "Purpose: 1. To maintain a record of any accident or incident that takes place at the facility. 2. To investigate and evaluate such occurrences with the intent of minimizing the likelihood of recurrence...2. The incident will be thoroughly investigated and all necessary precautions taken to prevent further incidents while the investigation is in progress...."</p> <p>A policy and procedure for Care Plans, with a last review date of 4/17/2013, was provided by the Minimum Data Set (MDS) Coordinator on 12/12/13 at 3:12 p.m. The policy included, but was not limited to, "Guidelines: It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. Responsibility: All members of the interdisciplinary</p>						

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	<p>team. Coordinated by the MDS Coordinator...Procedure...7. All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition...."</p> <p>3.1-45(a)(2)</p>				