

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

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|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155730 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 04/17/2013 |
| NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN 47031 | | |
| (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) COMPLETION DATE | |
| {F 000} | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (P.S.R.) to the Investigation of Complaints IN00123298, IN00124850, IN00124918, and IN00124998 completed on 03/08/2013.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00125904 and IN00126810.</p> <p>Complaints IN00123298, IN00124850, IN00124918, and IN00124998 - corrected.</p> <p>Survey dates: April 15, 16, 17, 2013</p> <p>Facility number: 000420 Provider number: 155730 AIM number: 100266230</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: SNF/NF: 93 Residential: 10 Total: 103</p> <p>Census payor type: Medicare: 14 Medicaid: 65 Other: 24 Total: 103</p> <p>Sample: 3</p> <p>Ripley Crossing was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaints IN00123298, IN00124850,</p> | {F 000} | | | |

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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| {F 000} | Continued From page 1 IN00124918, and IN00124998. Quality review 4/18/13 by Suzanne Williams, RN | {F 000} | | |