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|---|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155730 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>12/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br><br>RIPLEY CROSSING |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1200 WHITLATCH WAY<br>MILAN, IN47031  |                      |   |
| (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 |   |
| F0000   | <p>This visit was for the Investigation of Complaint IN00100634.</p> <p>Complaint IN00100634 - substantiated, Federal/State deficiencies related to the allegations are cited at F 223.</p> <p>Survey date: December 21, 2011</p> <p>Facility number: 000420<br/>Provider number: 155730<br/>AIM number: 100266230</p> <p>Survey team: Janie Faulkner, RN</p> <p>Census bed type:<br/>SNF/NF 96<br/>Residential 11<br/>Total 107</p> <p>Census Payor type:<br/>Medicare 10<br/>Medicaid 73<br/>Other 24<br/>Total 107</p> <p>Sample: 3</p> <p>Ripley Crossing was found to be in substantial compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint</p> | F0000   | <p><i>Ripley Crossing</i></p> <p><i>1200 Whitlatch Way</i></p> <p><i>Milan, IN 47031</i></p> <p><i>(812)</i><br/><i>654-2231 (Phone)</i><br/><i>)</i></p> <p><i>(812) 654-2240</i><br/><i>(Fax)</i></p> <p>055730</p> <p>100266230</p> <p>000420</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.

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|   | IN00100634.<br><br>Quality review completed 12/27/11<br>Cathy Emswiller RN   |   | 01/06/12<br><br>ISDH<br><br>2 N. Meridian Street<br><br>Indianapolis, IN 46204<br><br>Re: Survey Event ID BB0E11<br><br>Dear Kim Rhoades:<br><br>Enclosed is the plan of correction. I respectfully request a desk review for this plan of correction.<br><br>Sincerely,<br><br>Monica Ogden, HFA |                      |   |

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

PRINTED: 01/18/2012

FORM APPROVED

OMB NO. 0938-0391

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