STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155730	A. BUILDING 00 / B. WING	02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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 Bldg. 00	This visit was for the Recertification and State Licensure Survey. This includes a State Residential Licensure Survey. Survey dates: February 22, 23, 24, 25, 26, and 27, 2015 Facility number: 000420 Provider number: 155730 AIM number: 100266230 Survey team: Tammy Forthofer, RN, TC Julie Dover, RN Trudy Lytle, RN (February 25 & 26, 2015) Census bed type: SNF/NF: 95 Residential: 20 Total: 115 Census payor type: Medicare: 13 Medicaid: 60 Other: 22 Total: 95 Residential sample: 7	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155730		02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on March 6, 2015, by Janelyn Kulik, RN.			
F 329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to provide adequate monitoring and documentation of	F 329	It is the intent of Ripley Crossing to provide adequate monitoring and documentation of behaviors for a resident receiving PRN	03/29/2015

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 02/27/2015
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
	behaviors for a resident receiving the antianxiety medication, Xanax, for 1 of 5 residents reviewed for unnecessary drugs. (Resident #92) Findings include: Resident #92's record was reviewed on 02/26/2015 at 10:12 AM. She was admitted to the facility on 1/21/2013. Diagnoses included, but were not limited to, history of Dementia, Depression and Anxiety. Physician's Orders indicated, "Xanax 0.25 mg (milligrams), 1 tablet by mouth every 8 hours as needed" with a diagnosis of Anxiety states. Review of the Controlled Drug Record indicated Resident #92 received PRN "when necessary" Xanax 0.25 mg on the following dates and times: 12/10/2014 at 8:00 AM 01/04/2015 at 9:00 AM 01/11/2015 at 8:00 AM 01/14/2015 at 8:00 AM 01/19/2015 at 8:00 AM 02/11/2015 at 8:00 AM 02/12/2015 at 8:00 AM 02/12/2015 at 3:00 PM Review of the " Monthly Behavior Monitoring Flowsheet " for Resident #92		anti-anxiety medications. Corrective action taken for resident #92: Residents behavior monitoring flow sheet will be revised to include specific behaviors related to Resident #92, including the use of non-pharmacological interventions as outlined on the behavior monitoring flow sheet All charts of residents receiving PRN anti-anxiety meds will be audited for proper/consistent documentation between the behavior monitoring flow sheet and the MAR by 3-29-15 Inservice all nurses by 3-29-15 on the importance of consistent documentation between behavior monitoring flow sheet and the MAR when a PRN anti-anxiety med is given. Unit Managers/Designee will monitor all PRN anti-anxiety meds given for proper/consistent documentation Weekly times four, monthly times two, then quarterly. DON/Designee will review quarterly QA on all PRN anti-anxiety meds for proper documentation	

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 02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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
	indicated zero behavior episodes for the following dates and times and no flow sheet could be found for the month of February by nursing staff. 12/10/2014 at 8:00 AM 01/04/2015 at 9:00 AM 01/11/2015 at 8:00 AM 01/14/2015 at 8:00 AM 01/19/2015 at 8:00 AM Review of the "Nurse's Notes" for Resident #92, indicated no nursing entries documented for the following dates and times: 12/10/2014 at 8:00 AM 01/04/2015 at 9:00 AM 01/11/2015 at 8:00 AM 01/14/2015 at 8:00 AM 01/19/2015 at 8:00 AM 02/11/2015 at 8:00 AM 02/12/2015 at 8:00 AM 02/12/2015 at 3:00 PM Review of the electronic "Behavior Detail Report" for Resident #92 indicated "none of these behaviors apply" for the following dates and times: 12/10/2014 at 8:00 AM 01/04/2015 at 9:00 AM 01/11/2015 at 8:00 AM 01/14/2015 at 8:00 AM 01/19/2015 at 8:00 AM 02/11/2015 at 8:00 AM 02/12/2015 at 8:00 AM			

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 02/27/2015
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
	02/12/2015 at 3:00 PM During an interview on 02/26/2015 at 10:14 AM., RN #8 indicated "She gets that PRN. She only gets that when she needs it." She indicated the last dose the resident received of Xanax was on 2/12/15. RN #8 indicated Resident #92 had not had any episodes of anxiety or yelling out for the past 10 days. On 02/26/2015 at 10:21 AM, an interview with RN #8 indicated she had seen episodes occasionally, "especially when family leaves or the day after family leaves". She indicated "there may have been too much stimulation, therapy, and too many people for the resident." RN #8 indicated the physician wanted to try the resident on antianxiety medication after seeing the resident in a crying episode. Review of the Quarterly Minimum Data Set (MDS) assessment dated 12/13/14, indicated the resident's Brief Interview for Mental Status (BIMS) score was 03, indicating she was cognitively impaired. Omnibus Budget Reconciliation Act (OBRA) Annual Residential Review dated September 9, 2014 under the heading "Emotional/Affective/Behavioral Information" indicated Resident #92 was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155730		02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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
	not receiving behavioral services and does not see a psychiatrist and that her primary care physician monitored the use of her psychotropic medications. It also indicated that the resident had become more anxious, irritable, and verbally aggressive in recent years before she was started on medications for dementia. The resident had a major mental status decline in the past four years and increasing mood problems with anxiety and depression. Care plan for anxiety, dated 5/1/13, identified Anxiety as the problem. Interventions included, but were not limited to, approach resident in a warm and friendly manner, encourage resident to voice feelings, issues and concerns, offer support and reassurance, PRN antianxiety medications per order. Interventions appropriate for resident. Care plan indicated resident was "at risk for adverse effects r/t antianxiety med use prn (as needed) dx anxiety" and was dated 12/23/14. Goals indicated resident "will have no adverse effects: no increased lethargy, no decreased LOC, etc." Interventions included, but were not limited to, meds per order, monitor for effectiveness of meds, labs per order. Care plan up to date and appropriate.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155730		02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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
	3.1-48(a)(3)			
F 425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review the facility failed to provide pharmaceutical services of emergency kit storage of infusion therapy solutions for 1 of 5 wings observed. (Wing 4). Findings include:	F 425	It is the intent of Ripley Crossing to provide pharmaceutical services of emergency kit storage of infusion therapy. Corrective action taken for Wing 4 consultant pharmacy immediately notified and all EDK's in the facility were exchanged on 2-25-15. No residents were found to have been affected by the deficient practice.	03/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155730		02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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
	During an observation on 02/25/2015 at 9:55 AM, with LPN #9 on Wing 4 , the emergency medication supply kit was unsealed and contained one liter bag of 0.45% sodium chloride with an expiration date of 12/2014 and one liter bag of 5% dextrose in 0.9% sodium chloride solution with an expiration date of 01/2015. During an interview on 02/25/2015 at 10:14 AM, LPN #9 indicated the nurse on duty was responsible to notify the pharmacist when an emergency drug kit was opened. She was not aware of the pharmacy being notified. LPN #9 indicated one resident was receiving intravenous therapy (IV) in the facility. During an interview on 02/25/2015 at 10:48 AM, the DON (Director of Nursing), indicated the Consulting Pharmacy was responsible for the emergency supply kit. She indicated that once the kit's seal had been broken the Consulting Pharmacy was to be notified and the pharmacy would replace the used supplies. During an interview on 02/25/2015 at 11:07 AM, Pharmacist #7 indicated the procedure for replacing the emergency supply kit was for the facility to notify the consultant pharmacist upon the		To avoid having the potential of residents receiving expired IV fluids the EDK will be monitored monthly for expiration by the DON/Designee, In addition the consultant pharmacist will initial and date each EDK with monthly inspection To ensure the emergency supply kits are current the DON/Designee will monitor every kit monthly for expiration by 3-29-15	

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 02/27/2015
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
	emergency kit being opened and the consultant pharmacist was to check the emergency drug kits on a regular basis. Record review of IV Emergency Drug List, located on the outside of the kit, indicated the emergency medication supply kit contained one liter bag of 0.45% normal saline solution with an expiration date of 12/14 and one liter bag of 5% dextrose in 0.9% sodium chloride solution with an expiration date of 01/2015. Review of the "Emergency Kit Dispensing Information" sheet indicated the emergency medication supply kit's last documentation line indicated the kit was last resealed by the pharmacy on 10/28/2014. Review of the current policy and procedure form dated 09/01/2007 for "Medication Storage in the Facility", provided by the DON on 02/25/2015, indicated...E. Infusion therapy products' expiration dates and storage conditions were monitored by the consultant pharmacist during the inspection of medication storage areas. Review of the current policy and procedure form dated 09/01/2007 for "Medication Ordering and Receiving			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155730		02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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
	From Pharmacy" indicated ...N. The kits were inventoried by the (consultant pharmacist) at least every thirty days for completeness and expiration dating of the contents. The date of inventory was noted on the outside of the kits. 3.1-25(a) 3.1-25(o)			
F 431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155730		02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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
	The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure disposal of expired medication for 3 of 28 medications observed (Wing 2 and 4), and failed to properly label 2 of 28 medications observed. (Wing 2 and 4) 1. On 02/25/2015 at 7:35 AM, observation of the Wing 2 medication room with RN #10 showed the refrigerator contained one vial of Tuberculin solution with no open date on the vial or box. During an interview on 02/25/2015 at 7:38 AM, RN #10 indicated the Tuberculin solution vial did appear to be used and was not dated. She indicated she could not find an open date on the vial or box. RN #10 indicated the vial was received on 01/26/2015. On 02/26/2015 at 10:14 AM, observation of Wing 2 medication room with RN #8 indicated the Tuberculin solution vial	F 431	It is the intent of Ripley Crossing to ensure disposal of expired meds and to properly label/date opened medications Corrective action taken all nurses will be inserviced on proper disposal and labeling/dating opened medication by 3-29-15 DON/Designee will monitor disposal/labeling of tuberculin solution every 4 weeks times 24 weeks and then quarterly with QA to ensure compliance	03/29/2015

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 02/27/2015
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
	located in the refrigerator did not have an open date on the vial or the box. The vial was received on 01/26/2015 and had been in the refrigerator for 31 days. 2. On 02/25/2015 at 09:55 AM, observation of the Wing 4 medication room with LPN # 9 showed the refrigerator contained one vial of Tuberculin solution with no open date on the vial or box. During an interview on 02/25/2015 at 9:58 AM LPN #9 indicated the vial of Tuberculin was received on 01/26/2015 and did not have an open date on the vial or the box. She indicated the vial had been used and was about half full. She indicated the nurse was suppose to notify the pharmacy. Review of the policy and procedure form for "Medications/Drug Disposal Policy", dated 10/10/2014 and identified as current, was provided by the DON and indicated Expired or unused portions of a resident's medications will be disposed of safely, completely and according to lawful requirements... 2. Remove the medicine from the medication box or cart...c. If the medication is expired, be sure and reorder from pharmacy. Review of the current policy and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155730		02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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
	procedure form for "Medication Storage in the Facility" dated 09/01/2007, provided by the DON on 02/25/2015, indicated infusion therapy products and supplies are stored under ..... sterility conditions, and following the manufactures's recommendations or those of the supplier..... E. Infusion therapy products' expiration dates and storage conditions are monitored by the consultant pharmacist during the inspection of medication storage areas Reviewed on 02/27/2015 at 9:01 AM the manufactures's recommendations for Tuberculin indicated a vial of Tuberculin solution which had been entered and in use for 30 days should be discarded. 3.1-25(o) 3.1-25(k)(3)			
F 441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.			

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 02/27/2015
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
	(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were maintained related to hand washing and glove use for 2 of 3 observations of incontinence care. (Resident #98 & #99) 1. On 02/26/15 at 12:55 PM, CNA # 6 brought clean linen into Resident # 98's room from a covered linen cart. CNA #	F 441	It is the intent of Ripley Crossing to maintain an infection control program designed to help prevent the development and transmission of disease and infection Corrective action taken for residents #98 & #99; perineal care policy and hand washing policy including glove usage will be reviewed with all nursing staff by 3-29-15 Proficiency audits for perineal care including hand	03/29/2015

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 02/27/2015
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
	6 and CNA # 2 washed their hands for 18 seconds, 20 seconds. Both CNA's placed on gloves. The resident's brief was pulled down and she was rolled to her right side by CNA #6. CNA #2 used a clean wash cloth to remove feces from the residents bottom, wiping from front to back. CNA #6 used a dry towel to dry the resident's bottom. The resident was rolled on her back and CNA # 2 used a clean wash cloth and wiped the front peri area, starting on the right side, then folding the cloth over and wiped the left side, next she folded the wash cloth over again and wiped the center fold. A clean wash cloth was used by CNA #2 to clean the catheter tubing starting at the peri area down towards the catheter bag. Those areas were dried after cleaning. The same pair of gloves were worn for the entire care by CNA #2 & #6. CNA #6 emptied the catheter bag into a plastic beaker and walked into the resident's restroom and emptied the beaker into the toilet. After removing her gloves CNA #2 washed her hands for 16 seconds, CNA # 6 removed her gloves and walked out of the room without washing her hands carrying the plastic bag containing soiled towels. During an interview on 02/27/2015 at 9:54 AM, CNA #6 indicated the proper procedure to perform perineal and		washing and glove usage will be performed with return demonstration by direct care staff at least 3 per shift per month then one per shift times one month, then randomly thereafter to ensure compliance DON/Designee will monitor	

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 02/27/2015
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
	catheter care was to remove your gloves if they become soiled and replaced with a clean pair. Gloves should always be changed after cleaning feces before continuing to clean the catheter tubing. Record review on 02/26/2015 at 3:20 PM for Resident #98 indicated diagnoses including, but not limited to, bladder spasms, urinary retention, chronic UTI's, urinary obstruction secondary urinary retention. 2. On 02/26/15 at 2:06 PM, CNA # 3 brought clean linen into Resident # 99's room from a covered linen cart. CNA # 2 and CNA # 1 washed their hands for 20 seconds, 22 seconds. The resident's brief was pulled down, alternating clean washcloths were used and folded between swipes, starting with the penis, then the scrotum, the creases to each side. Those areas were dried after cleaning. The catheter tubing was not observed to be cleaned in the 4 inches from the tip of the penis. The same pair of gloves was worn for the entire care. CNA # 1 washed her hands for 18 seconds , CNA # 2 washed her hands for 10 seconds, CNA # 3 washed her hands for 22 seconds. On 02/26/15 at 2:25 PM, CNA # 3 indicated "we get a paper towel, turn on the sink, throw the paper towel away, 3			

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 02/27/2015
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
	squirts of soap, rub the back of the hand, then the thumb on each side, then the knuckles on each side, then between the fingers, for 20 seconds but we try for 30 seconds, rinse off from the wrist down, get a paper towel, pat from the wrist to tip of fingers on each hand, then the top surface with another paper towel, turn off the water with another paper towel. Change your gloves when an area is switched or dirty". During an interview on 02/26/15 at 11:01 AM with CNA # 4 and CNA # 5, they indicated to "Turn the water on, put soap on your hands, wash 20 seconds, rinse hand down, dry hands, use paper towel to turn off water, throw into trash. We provide toileting to our residents every 2 hours." On 02/26/15 at 3:18 PM the DON, indicated "the staff wash their hands for at least 20 seconds, put their gloves on, do the procedure and wash their hands for 20 seconds. If the gloves become soiled they need to change their gloves. If they are contaminated, or if they touch anything other than what they are doing, they need to change their gloves. If it is dressing change then they need to change gloves before applying fresh dressing. The gloves should be changed when going from cleaning the front of the			

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 02/27/2015
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
	resident (peri area) to cleaning the back of the resident (anal area). I do consider the gloves to be contaminated when the CNA is cleaning the peri area and the gloves should be changed before rinsing and drying." On 02/26/15 at 3:20 PM, the review of the Perineal Care Policy and Procedure, provided by the DON, indicated, "1. Wash hands... 4. put on disposable gloves... 9. e. Change gloves as needed." The review of the Hand Washing Policy indicated the "Purpose: 1. To prevent the spread of infection or disease from resident to resident, staff to resident and resident to staff. 2. To preserve the health and safety of residents and staff. Policy: Hand washing will be done before and after direct resident care, before and after removal of gloves and on completion of each task/job...Procedure: A: Soap and water: 1. Turn water on to comfortable temperature. 2. Moisten hands with water and apply soap. 3. Wash hands well for at least 20 seconds to aid in the mechanical removal of bacteria. 4. Wash areas between fingers, around nail beds and under fingernails. 5. Rinse well under running water. 6. Grasp paper towel and blot or pat hands dry. 7. Turn off the water. 8. Dispose of paper towel in the wastebasket." The review of the Urinary Catheter			

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 02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	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
	Maintenance indicated the "Purpose: To provide a urinary elimination system while minimizing the chance for cross-contamination and recurrent UTIs. Policy: To ensure cleanliness of a closed urinary drainage system by cleaning the urinary meatus at least two times per day and as necessary, plus changing drainage bag and tubing as needed. Procedure: 1. Wash hands. 2. Explain the procedure to resident and being equipment to bedside. 3. Put on gloves. Key Points: Hands shall be washed before and after touching any part of the catheter drainage system. Provide Privacy." 3.1-18(i)(l)			
R 000 Bldg. 00	Ripley Crossing was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on March 6, 2015, by Janelyn Kulik, RN.	R 000		