STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155730	A. BUILDING 00 B. WING	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIPLEY CROSSING	1200 WHITLATCH WAY MILAN, IN 47031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00433609, IN00434552, and IN00434924. Complaint IN00433609 - No deficiencies related to the allegation are cited. Complaint IN00434552 - No deficiencies related to the allegation are cited. Complaint IN00434924 - Federal/State deficiencies related to the allegation are cited at F600 and F609. Survey dates: June 4 and 5, 2024 Facility number: 000420 Provider number: 155730 AIM number: 100266230 Census Bed Type: SNF/NF: 81 Residential: 21 Total: 102 Census Payor Type: Medicare: 3 Medicaid: 59 Other: 19 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 7, 2024.	F 0000		
F 0600 SS=D	483.12(a)(1) Free from Abuse and Neglect			

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

Trina Johnson | Administrator | 06/17/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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Bldg. 00	§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview the facility failed to ensure residents were free from verbal and emotional abuse for 2 of 3 residents reviewed for abuse. (Residents D and B) Findings include: 1. The clinical record for Resident D was reviewed on 06/04/24 at 11:15 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 04/13/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Parkinson's disease, and hypertension. During an interview on 06/04/24 at 9:49 A.M., Resident D indicated she had been mistreated by CNA (Certified Nurse Aide) 5 at the facility. Her roommate (Resident B) couldn't reach her call light and Resident D had been helping her with the blankets on her bed. CNA 5 came into their room and thought Resident D was trying to transfer Resident B into bed. CNA 5 yelled at her and told her to get back to the other side of the room. The resident indicated she wasn't doing anything	F 0600	It is the intent of Ripley Crossing to provide an environment where all residents are free from abuse. Corrective Action – Staff involved were immediately educated on Abuse Prevention and Reporting. Social Services conducted an in-service to nursing staff on May 20, 2024 on Abuse Prohibition/Know your Role and Abuse Protocol. To ensure compliance we have moved up the Full Staff Abuse In-Service to June 20, 2024. The Abuse Coordinator will monitor all incidents and will report if appropriate. This is ongoing Measures put in place include daily monitoring of incidents and reporting such incidents. This is ongoing. Abuse Coordinator, Director of Nursing, Administrator or designee will monitor.	06/20/2024

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	wrong. CNA 3 was there when it happened. The resident had heard CNA 5 had been fired. The SSD (Social Services Director) did talk to her and had asked her about the incident. A Progress Note written by LPN 4 (Licensed Practical Nurse), dated 05/19/24 at 5:27 P.M., indicated Resident D had spoken with her about an incident that happened the night before. The resident was upset with the CNAs on the evening shift after she said she was trying to help her roommate get her call light within reach and a CNA entered the room believing she was trying to assist her roommate to bed. She said a CNA yelled at her to get to her own side of the room. Apparently, an argument ensued between the CNA and the resident at that time. The roommate became upset over the confrontation and started to cry. This nurse had spoken with both residents in their room and received the same story. LPN 4 assured the residents that the incident would be addressed, and both residents were satisfied. 2. The clinical record for Resident B was reviewed on 06/04/24 at 11:26 A.M. A Quarterly MDS assessment, dated 03/13/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, diabetes, anxiety, and depression. During an interview on 06/05/24 at 1:38 P.M., Resident B indicated on the night of the incident she was getting ready for bed. Her roommate (Resident D) was helping her with some things. CNA 5 came in and started yelling at Resident D. CNA 5 thought Resident D was assisting Resident B into bed and she was not. CNA 5 left the room and CNA 3 finished helping Resident B. The whole incident upset her a little. The residents were not doing anything wrong, and			

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	CNA 5 yelled at Resident D. CNA 5 shouldn't have yelled at the resident. During the interview, Resident D indicated the residents would always hear CNA 5 yelling in the facility, but they never told anyone about it. During an interview on 06/04/24 at 2:08 P.M., CNA 3 indicated she had worked with CNA 5 on the evening of 05/18/24. CNA 3 went in Resident B and D's room that evening because Resident B's call light was on. Resident D was upset and told her that Resident B had not had her call light all day, that it had been out of her reach. Resident D was aggravated. CNA 3 felt like she needed help and had CNA 5 come in to assist her. When the CNAs returned to the room, Resident D was holding onto Resident B's wheelchair. CNA 5 told Resident D to go to her own side of the room. CNA 5 said it again and started getting louder. Resident D told CNA 5 to "shut up". Resident B was getting teary eyed. CNA 3 was helping Resident B, and she was unsure of what Resident D was saying, it seemed like she said she wanted to go home. CNA 3 tried to keep everyone calm. CNA 5 was speaking in a louder voice than normal. CNA 3 made CNA 5 get out of the room. Other residents had expressed concerns regarding CNA 5 complaining a lot in the past. CNA 3 thought CNA 5 told the nurse about the incident. CNA 3 didn't report the incident to the nurse on duty, her brain went into a fog, and she was trying to get to another call light that was going off. CNA 5 worked the rest of the shift that night and worked the next day with CNA 3. CNA 3 indicated she was supposed to talk to the nurse in charge about what happened, and she failed to do that. She just was trying to get her residents taken care of. The "as worked" nursing schedule for 05/18/24			

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	and 05/19/24 was provided by the ADON (Assistant Director of Nursing) on 06/04/24 at 1:25 P.M. The record indicated CNA 5 and CNA 3 had worked on Wing 1 on both days from 2:00 P.M. to 10:00 P.M. During an interview on 06/04/24 at 1:38 P.M., LPN 2 indicated she remembered the incident from 05/18/24. It was in the evening; she was passing medications on Wing 1. CNA 3 was in the common area and asked CNA 5 to help her. Shortly after that, LPN 2 heard yelling. She went into the residents' room. Resident B was in bed and Resident D was sitting on her own bed. The two CNAs were not in the room. LPN 2 asked if everything was okay. Resident D indicated she would never do the things CNA 5 accused her of. She accused her of helping Resident B to walk. Resident D said she was just helping Resident B get her call light. LPN 2 tried to lighten the mood because Resident D seemed a little shaky. Resident D indicated she wanted to go home. Resident D indicated those CNAs were always rude to her. LPN 2 made sure the residents had their call lights and left the room. CNA 5 and CNA 3 were just sitting at the nurse's station. It was getting close to time for their shift to be over. LPN 2 did not say anything to the CNAs. She reported what happened to the oncoming nurse at 10:00 P.M. The Administrator had LPN 2 come into the facility on 05/20/24 and talked to her about the incident. During an interview on 06/05/24 at 2:14 P.M., LPN 7 indicated if she encountered a situation where a staff member was being abusive towards a resident she would immediately separate the two. She would make sure the resident was safe. She would call the Administrator and the Social Services Director at any time day or night. She			

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	would not wait, she would call them immediately, she wouldn't leave it for the next shift. During an interview on 06/04/2024 at 10:30 A.M., the Administrator indicated the staff were in-serviced and educated on abuse and neglect upon hire, annually, and any time there was an allegation of abuse or neglect. Education on abuse and neglect was part of the staff's orientation upon hire. After that, education was done annually facility wide. Signs were posted on every wing, by the time clock, and in the break room regarding reporting abuse. The signs were bright orange in color. They had not had any concerns with CNA 5 regarding abuse in the past. Residents B and D were alert and oriented. Both residents had the same story. CNA 3 came into the residents' room and had CNA 5 leave the room. The SSD was the Abuse Coordinator for the facility. Staff were supposed to call him, day, or night, to report any allegations or suspected abuse immediately. The current policy and procedure for "Abuse, Neglect and Exploitation" was provided by the Administrator on 06/04/24 at 11:20 A.M. The policy indicated, "...It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse...Verbal Abuse...means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability...Mental Abuse...includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation...An immediate investigation is warranted when suspicion of			

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	abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur...Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator ...Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies...within specific timeframes...Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or...Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury ..." This citation relates to Complaint IN00434924. 3.1-27(a)(1) 5.1-27(b)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey			

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	Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed ensure staff reported an allegation of abuse in a timely manner for 2 of 3 residents reviewed for abuse. (Residents D and B) Findings include: During an interview on 06/04/24 at 2:08 P.M., CNA (Certified Nurse Aide) 3 indicated she had worked with CNA 5 on the evening of 05/18/24. The CNAs entered Resident B and D's room to assist Resident B with care. Resident D was holding onto Resident B's wheelchair. CNA 5 told Resident D to go to her own side of the room. CNA 5 said it again and started getting louder. Resident D told CNA 5 to "shut up". Resident B was getting teary eyed. CNA 3 was helping Resident B, and she was unsure of what Resident D was saying, it seemed like she said she wanted to go home. CNA 3 tried to keep everyone calm. CNA 5 was speaking in a louder voice than normal. CNA 3 made CNA 5 get out of the room. CNA 3 didn't report the incident to the nurse on duty. CNA 5 worked the rest of the shift that night and worked the next day with CNA 3. CNA 3 indicated she was supposed to talk to the nurse in charge about what happened, and she failed to do	F 0609	It is the intent of Ripley Crossing to report all allegations of abuse. Corrective Action – Staff involved were immediately educated on Abuse Prevention and Reporting. Social Services conducted an in-service to nursing staff on May 20, 2024 on Abuse Prohibition/Know your Role, Report Immediately and Abuse Protocol. To ensure compliance we have moved up the Full Staff Abuse In-Service to June 20, 2024. All incidents outlined in the IDOH Incident Reporting Policy will be reported per their guidelines. The Abuse Coordinator will monitor all incidents and will report if appropriate. This is ongoing. Measures put in place include daily monitoring of incidents and reporting of such incidents immediately. This is ongoing. Abuse Coordinator, Director of Nursing, Administrator or designee will monitor.	06/20/2024

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	that. During an interview on 06/04/24 at 1:38 P.M., LPN (Licensed Practical Nurse) 2 indicated she remembered the incident from 05/18/24. She heard some yelling in the direction of Resident B and D's room. When she entered the room, Resident B was in bed and Resident D was sitting on her own bed. The two CNAs were not in the room. Resident D indicated CNA 5 accused her of trying to help Resident B to walk. LPN 2 tried to lighten the mood because Resident D seemed a little shaky. Resident D indicated she wanted to go home. Resident D indicated those CNAs were always rude to her. LPN 2 made sure the residents had their call lights and left the room. CNA 5 and CNA 3 were just sitting at the nurse's station. It was getting close to time for their shift to be over. LPN 2 did not say anything to the CNAs. She reported what happened to the oncoming nurse at 10:00 P.M. A Progress Note written by LPN 4, dated 05/19/24 at 5:27 P.M., indicated Resident D had spoken with her about an incident that happened the night before. The resident was upset with the CNAs on the evening shift after she said she was trying to help her roommate get her call light within reach and a CNA entered the room believing she was trying to assist her roommate to bed. She said a CNA yelled at her to get to her own side of the room. Apparently, an argument ensued between the CNA and the resident at that time. The roommate became upset over the confrontation and started to cry. This nurse spoke with both residents in their room and received the same story. LPN 4 assured the residents that the incident would be addressed. There was no indication in Resident B or Resident			

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	D's records that the Administrator or SSD (Social Services Director) were notified of the incident. During an interview with the DON (Director of Nursing) and SSD on 06/05/24 at 9:46 A.M., the SSD indicated he came into work on 05/20/24 and found out about the incident when he was reviewing resident progress notes from over the weekend. Once he saw LPN 4's note about what happened, he immediately notified the Administrator and DON and started his investigation. He spoke with both residents. They remembered the incident. Both residents were very calm and showed no signs of psychological distress. The resident's families were notified, and the staff involved were interviewed. Staff were educated about reporting abuse. CNA 5 was initially suspended and then fired. During an interview on 06/05/24 at 2:14 P.M., LPN 7 indicated if she encountered a situation where a staff member was being abusive towards a resident she would immediately separate the two. She would make sure the resident was safe. She would call the Administrator and the Social Services Director at any time day or night. She would not wait, she would call them immediately, she wouldn't leave it for the next shift. During an interview on 06/05/24 at 2:11 P.M., CNA 6 indicated If she came upon a situation where a staff member was yelling at a resident or abusing a resident in any way, she would immediately intervene. She would make sure the resident was safe, she wouldn't leave the resident and she would tell the nurse what was going on. During an interview on 06/04/2024 at 10:30 A.M., the Administrator indicated the staff were in-serviced and educated on abuse and neglect			

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	upon hire, annually, and any time there was an allegation of abuse or neglect. Education on abuse and neglect was part of the staff's orientation upon hire. After that, education was done annually facility wide. Signs were posted on every wing, by the time clock, and in the break room regarding reporting abuse. The signs were bright orange in color. The SSD was the Abuse Coordinator for the facility. Staff were supposed to call him, day, or night, to report any allegations or suspected abuse immediately. The current policy and procedure for "Abuse, Neglect and Exploitation" was provided by the Administrator on 06/04/24 at 11:20 A.M. The policy indicated, "...It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse...Verbal Abuse...means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability...Mental Abuse...includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation...An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur...Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies...within specific timeframes...Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or...Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily			

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	injury ..." This citation relates to Complaint IN00434924. 3.1-28(c)			