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	09/19/2022

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 a Recertification and State Licensure Survey and the Investigation of Complaint IN00385278. This visit included a State Residential Licensure Survey. Complaint IN00385278 - Unsubstantiated due to lack of evidence. Survey dates: September 12, 13, 14, 15, 16, and 19, 2022 Facility number: 000420 Provider number: 155730 AIM number: 100266230 Census Bed Type: SNF/NF: 70 Residential: 19 Total: 89 Census Payor Type: Medicare: 1 Medicaid: 58 Other: 11 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 27, 2022.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, observation, and record review, the facility failed to adequately monitor and administer treatments to surgical sites that became infected for 1 of 4 residents reviewed for Quality of Care related to non-pressure skin conditions. (Resident 49) Findings include: During an interview on 09/12/22 at 12:23 P.M., Resident 49 indicated he recently had surgery on some areas on his back. He was currently taking antibiotics for an infection in the wounds. During an interview on 09/14/22 at 10:47 A.M., LPN (Licensed Practical Nurse) 5 indicated the resident had two lipomas removed, so he had two incisions on his back. Currently, the treatment was to cleanse the areas with soap and water each shift until they were healed. The resident was receiving an antibiotic for an infection in the wounds. Since the resident was taking an antibiotic, nursing staff documented observations of the wounds and monitored the resident related to antibiotic usage in a progress note each shift. She didn't think the surgical sites were monitored in the resident's clinical record before the infection was identified. The resident's surgical incisions were observed with LPN 7 on 09/16/22 at 10:26 A.M. There were only faint lines where the incisions were that measured approximately 2.5 cm (centimeters) and 1.5 cm in length. There was no drainage, redness,	F 0684	1. Documentation of treatments provided every shift of resident 49's surgical wound since 9/19/22 is present in Resident 49's medical record. Surgical wound healed on 9/24/22. 2. On 9/26/2022, skin assessments were completed on all residents currently residing in the facility by the Asst. Director of Nursing to ensure all non-pressure skin conditions are adequately monitored and treatments provided and documented for all identified non-pressure skin conditions. 3. On 10/4/2022 the Director of Nursing and Asst. Director of Nursing began re-educating all licensed nurses on the requirement to document treatments provided at the time of each treatment and surgical site monitoring every shift in the clinical record and on the new Surgical Incision Protocol. 4. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance (QA) tool to monitor that treatments are documented at the time of completion and every shift	10/07/2022

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	or other signs of infection. The sutures had been removed and the wounds were nearly healed. The resident's clinical record was reviewed on 09/19/22 at 9:25 A.M. An Admission MDS (Minimum Data Set) assessment, dated 08/24/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, heart failure, hypertension, and diabetes. The resident was at risk for pressure ulcers but had no ulcers or wounds on his skin during the assessment review period. A Report of Consultation Note in the resident's chart, dated 08/29/22, indicated the resident underwent a surgical procedure. The resident could shower. The resident's suture lines were to be cleansed daily with soap and water, and the resident could use an ice pack for pain. Follow up with the MD in 10 to 14 days. A Progress Note, dated 08/29/22 at 1:37 P.M., indicated the resident could shower and use an ice pack to his back as needed. The resident was to follow up with the doctor in 10 to 14 days to remove the sutures on his back. The resident's clinical record lacked documentation that the resident's surgical sites were cleansed daily or monitored after the surgical procedure on 08/28/22 until 09/08/22. A Progress Note, dated 09/08/22 at 1:44 P.M., indicated the incisions on the resident's back were red, swollen, and draining clear fluid and blood. The areas were cleansed, and a dressing was applied. The sutures remained intact. A call was placed to the MD's office, and a possible infection was reported to the nurse.		monitoring of surgical sites are included in the clinical record through auditing of Treatment Administration Records (TARS) and progress notes of all residents with surgical wounds daily for 5 days, then weekly for 6 weeks, then monthly to ensure treatments are documented when provided and monitoring of surgical wounds is documented every shift. This tool will be completed for 6 months and until compliance is maintained by the Director of Nursing or designee. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. The facility, through the QAPI program, will review, update, and make changes to this plan of correction until 100% compliance is sustained for no less than six months.	

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	An Order Note, dated 09/08/2022 at 5:01 P.M., indicated a physician's order was entered for Bactrim DS (an antibiotic). Give 1 tablet by mouth two times a day for the infected incisions for 10 days. A Progress Note, dated 09/09/22 at 10:34 A.M., indicated the MD was in to check the incisions on the resident's back. The physician removed 1 stitch from the lower incision and 2 stitches from upper incision to aid in draining the infection. During an interview on 09/19/22 at 12:13 P.M., the DON (Director of Nursing) indicated normally nursing staff would monitor a surgical site each shift. They would observe for signs of infection and count the sutures, if applicable. The resident did come back with a dressing on his back, the MD indicated when the dressing fell off, they could just leave it off. The wounds did get infected. There should be documentation of the treatment and documentation that the surgical sites were monitored in the resident's clinical record. The current facility policy, titled "Documentation of Wound Treatments", with a revision date of 11/24/21, was provided by the DON on 09/19/22 at 1:50 P.M. The policy indicated, "...The facility completes accurate documentation of wound assessments and treatments...wound treatments are documented at the time of each treatment...if no treatment is due, and indication on the status of the dressing shall be documented each shift..." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer			

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	§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to monitor, accurately stage, and administer treatments appropriately for 1 of 1 resident reviewed for pressure ulcers. (Resident 60) Findings include: During an observation on 09/16/22 at 11:23 P.M., LPN (Licensed Practical Nurse) 2 had gathered supplies from a medication room on Wing 2. She went to Resident 60's room, closed the door. She donned the gloves, held the bed controller with her gloved right hand and raised the bed, removed the residents covers, and explained what she was going to do. All of the wound treatment supplies were laying on the resident's bed. The resident was lying on her left side. The nurse removed the brief covering the resident's buttocks and removed an undated dressing on the resident's coccyx. The nurse then covered the resident, removed her gloves, indicated she had forgotten her wound cleanser and left the room. She returned within a few moments and donned gloves that were sitting on the bedside table. The	F 0686	1.On 10/7/2022 LPN 2 was re-educated by the Director of Nursing on the procedure for administering wound treatments, including infection prevention and control procedures to follow when performing wound treatments. Resident #60 no longer resides at facility. 2. On 10/4/2022, skin assessments were completed on all residents currently residing in the facility by the Asst. Director of Nursing to ensure all pressure ulcers present are adequately monitored, accurately staged and treatments administered appropriately for all residents with pressure ulcers. 3. On 10/4/2022 the Director of Nursing and Asst. Director of Nursing began re-educated all licensed nurses on the requirement to monitor, accurately stage, and administer treatments	10/07/2022

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	nurse removed the blanket, sprayed wound cleanser on a gauze pad, and cleansed the wound. She threw the gauze into the garbage can. She applied medihoney cream to a gauze pad and then indicated she wasn't going to use the cream she was going to use a medihoney strip. The strip was applied to the wound using her gloved right hand. She opened a foam dressing and had touched the inside of the dressing with her gloved right hand and placed the dressing over the wound. The wound was approximately the size of a silver dollar and black in color. The skin surrounding the outside of the wound was pink. LPN 2 indicated The nurse on the floor complete the wound assessments weekly that included staging the wounds. She would consider the resident's wound a Stage 2 (partial-thickness skin loss with exposed dermis) pressure ulcer based on the reference to what a Stage 2 pressure ulcer was. The clinical record for Resident 60 was reviewed on 09/13/22 at 3:01 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/31/22, indicated the resident was severely cognitively impaired. The diagnoses included but were not limited to, diabetes, depression, hypertension, and Alzheimer's disease. A Wound Weekly Observation Tool, dated 05/11/22, indicated the resident had MASD (Moister Associated Skin Damage) to the upper coccyx and buttocks. The area was moist with granulation (beefy red) tissue present. The area measured 0.2 cm (centimeters) X (by) 0.2 cm. The treatment plan was for calmoseptine (moisture barrier cream) every shift and as needed. The resident's clinical record including the May 2022 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment		appropriately for pressure ulcers and competency evaluation was completed on all licensed nurses to ensure competence in appropriately assessing and treating pressure ulcers, including accurate staging and following appropriate infection prevention and control procedures during wound treatments. 4. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool to monitor that pressure ulcers are monitored, accurately staged, and treatments administered appropriately weekly for 6 weeks, then monthly to ensure pressure ulcers are monitored, accurately staged, and treatments are administered appropriately. Random treatment observations will be completed on 5 licensed nurses per week for 6 weeks and then 5 licensed nurses per month to ensure treatments provided per the facility Wound Care policy. This tool will be completed for 6 months and until compliance is maintained by the Director of Nursing or designee. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. The facility, through the QAPI program, will review, update, and make	

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	Administration Record) lacked documentation that the treatment for calmoseptine was initiated. The clinical record lacked a weekly wound assessment from 05/11/22 through 06/28/22 for the MASD to the coccyx. A Wound Weekly Observation Tool, dated 06/28/22, indicated the resident had a facility acquired Stage 2 pressure ulcer to the coccyx with a start date of 06/28/22. There was epithelial (pink) tissue present with a moderate amount of serosanguineous (yellow with small amounts of blood) drainage. The wound measured 1.5 cm X 1.5 cm. A treatment was initiated. A Wound Weekly Observation Tool, dated 07/27/22, indicated the resident had a facility acquired Stage 2 pressure ulcer to the coccyx. There was epithelial (pink) tissue present. The wound measured 1.8 cm X 1.8 cm. The wound was worsening, and a new treatment was initiated. A Wound Weekly Observation Tool, dated 08/10/22, indicated the resident had a facility acquired Stage 2 pressure ulcer to the coccyx. There was 90% slough (yellow, tan, white, stringy) tissue present with a scant amount of purulent (white, yellow, brown) drainage. The wound measured 1.5 cm X 1.5 cm. There were no changes in the treatment plan. A Wound Weekly Observation Tool, dated 08/18/22, indicated the resident had a facility acquired Stage 2 pressure ulcer to the coccyx. There was 75% slough tissue present with a scant amount of purulent drainage. The wound measured 0.9 cm X 1.0 cm. There were no changes in the treatment plan.		changes to this plan of correction until 100% compliance is sustained for no less than six months.	

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	A Wound Weekly Observation Tool, dated 08/31/22, indicated the resident had a facility acquired Stage 2 pressure ulcer to the coccyx. There was a dark scabbed area over the wound. The wound measured 1.5 cm X 1.5 cm and was worsening. There were no changes in the treatment plan. A Wound Weekly Observation Tool, dated 09/07/22, indicated the resident had an area to the coccyx. The wound area was scabbed over and the wound itself was bigger. The wound measured 3.5 cm X 2.5 cm. The treatment was changed from twice a day to once a day. During an interview on 09/16/22 at 1:45 P.M., the DON (Director of Nursing)/ ADON (Assistant Director of Nursing) indicated the resident's wound had looked necrotic last week and the dressing had recently been changed from twice a day to once a day. The resident's wound at this time was Unstageable (Full thickness tissue loss in which actual depth of the ulcer was completely obscured by slough and/or eschar [dead tissue] in the wound bed) due to the amount of necrosis. Any wounds would be assessed weekly by the nurses on the floor, and they would look at them as needed. The nurses would document the staging of the wounds and if they were worsening. The nurses input the new orders related to treatments for skins/wounds. This resident didn't typically sleep in bed and liked to sleep in a recliner. The resident had a care plan to turn and reposition while in bed, a pressure reducing cushion to the wheelchair, and to toilet with meals and at bedtime. They were unsure if therapy had worked with the resident on any skin concerns and sleeping in the recliner. The current facility policy, titled "Prevention of			

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	Pressure Injuries" with a revised date of April 2020, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable...Asses the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition..." The current facility policy, titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol" with a revised date of April 2018, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...In addition, the nurse shall describe and document/report the following: Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudate or necrotic...Monitoring...During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds..." The current facility policy, titled "Wound Care", with a revised date of October 2010, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...The purpose of this procedure is to provide guidelines for the care of wounds to promote healing...use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Wash and dry your hands thoroughly. Position resident. Put on exam gloves. Loosen tape and remove dressing. Pull Gloves over dressing and discard...Wash and dry your hands thoroughly. Put on gloves...Use no touch technique...Dress wound...Be certain all clean items are on clean field...Wash and dry your			

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	hands thoroughly..." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to follow interventions for a fall for 1 of 3 residents reviewed for accidents. (Resident 60) Findings include: The clinical record for Resident 60 was reviewed on 09/13/22 at 3:01 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/31/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, diabetes, depression, hypertension, and Alzheimer's disease. An Incident Documentation and Investigation Tool, dated 06/29/22, indicated the resident had an unwitnessed fall in the common area. The resident had been sitting at the breakfast table in the common area and slid out of her wheelchair. A new intervention was initiated for dycem to the wheelchair. An Incident Documentation and Investigation	F 0689	1. Resident 60 no longer resides at the facility 2. On 10/5/2022 the IDT, consisting of the Director of Nursing and Asst. Director of Nursing, reviewed the fall care plans for all current in-house residents to ensure that care planned fall interventions are followed. 3. On 10/4/2022 the Director of Nursing and Asst. Director of nursing began re-educating all nursing staff on the requirement to ensure that fall interventions are followed. Fall care plan interventions for each resident identified as high risk for falls were added to the Treatment Administration Record for nurses to check and document every shift that fall interventions are followed, it was also added to the Point of	10/07/2022

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	Tool, dated 08/24/22, indicated the resident had an unwitnessed fall in the common area. The resident had been sitting in her wheelchair. The resident's dycem was not in her wheelchair at the time of the incident. During an interview on 09/16/22 at 10:31 A.M., the DON (Director of Nursing) indicated the nursing staff should follow all interventions for resident's and the staff were reeducated to ensure the dycem was in place. An Incident Documentation and Investigation Tool, dated 09/05/22, indicated the resident had a witnessed fall. CNAs (Certified Nurse Aide) 3 and 9 were attempting to transfer the resident to the recliner when the resident leaned forward and fell out of her chair. The CNAs were educated to use a gait belt when transferring residents. During an observation on 09/14/22 at 2:17 P.M., the ADON (Assistant Director of Nursing) and the DON were assisting Resident 60 from her wheelchair to a recliner in the common area. The ADON had her left arm under Resident 60's left arm and was pulling the resident up while the DON assisted with grabbing the resident's pants on the left side and help by pushing on the residents left hip to turn her towards a recliner. A gait belt was not in use. During an interview on 09/15/22 at 3:20 P.M., CNA 4 indicated on 09/05/22 she was going to assist CNA 9 to assist Resident 60 into a recliner in the common area. The nurse wanted to assess the resident's vital signs before staff assisted her out of her wheelchair. CNA 4 put her hand on the resident's shoulder to wait for the nurse and had moved it away for a brief second when the resident leaned forward and fell to the floor. They		Care for CNAs to check every shift that fall interventions are followed. 4. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool to monitor that fall prevention interventions are in place as per plan of care with AM and PM supervisory rounds five days per week for 4 weeks; then random sample of 5% of residents weekly for 4 weeks, then monthly. The QA tool will be completed for 6 months and until compliance is maintained by the Director of Nursing or designee. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. The facility, through the QAPI program, will review, update, and make changes to this plan of correction until 100% compliance is sustained for no less than six months.	

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were not in the process of physically transferring the resident. CNA 4 and CNA 9 were educated to use a gait belt with transfers.

During an interview on 09/16/22 at 10:31 A.M., the DON indicated a fall packet was completed with each fall and an assessment was completed in the computer. The ADON would review the packets. New interventions would be put into place and updated on the care plan. A therapist would evaluate the resident within two to three days after a fall. They would talk to the staff involved after a fall if they had doubts about a report. Staff members should use gait belts when transferring residents.

The current facility policy, titled "Falls-Clinical Protocol", with a revised date of March 2018, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...Based on preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling..."

The current facility policy, titled "Assessing Falls and Their Causes", with a revised date of March 2018, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...The purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall..."

The current facility policy, titled "Gait Belt", with a revised date of 09/23/19, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...To prevent injury to staff members and residents while offering security and balance to resident during a transfer or while ambulating...Gait belts are available for staff to

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	facilitate transfers utilizing proper body mechanics for both residents and staff. All staff will be educated in the proper use of gait belts for transfer and ambulation assistance...Failure to utilize gait belts on designated resident is a danger to BOTH the resident and the staff member..." 3.1-45(a)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to follow a physician's order related to a blood glucose medication for 1 of 6 residents reviewed for unnecessary medications. (Resident	F 0757	1. Resident 60 no longer resides at the facility. 2. On 9/30/2022, the Director of Nursing and Asst. Director of	10/07/2022

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	60) Findings include: The clinical record for Resident 60 was reviewed on 09/13/22 at 3:01 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/31/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, diabetes, depression, hypertension, and Alzheimer's disease. A Physician Progress Note, dated 07/25/22, indicated the resident's assessment and plan was to continue metformin (a diabetic medication) 500 mg (milligrams), twice a day, and to hold the medication for a blood sugar that was less than or equal to 90. An open-ended physician's order, with a start date of 07/25/22, indicated the resident was to receive Metformin 500 mg, upon rising, in the morning for diabetes. The medication was to be held for a blood glucose less than 90. The July through September 2022 EMAR (Electronic Medication Administration Record) indicated the resident had received the Metformin medication in the morning when her blood glucose was less than 90 on the following dates: - 07/28/22, the blood glucose was 69, - 07/31/22, the blood glucose was 67, - 08/07/22, the blood glucose was 64, - 08/10/22, the blood glucose was 83, - 08/11/22, the blood glucose was 53, - 08/12/22, the blood glucose was 83, - 08/20/22, the blood glucose was 74, - 08/21/22, the blood glucose was 83, - 09/01/22, the blood glucose was 87, and		Nursing, reviewed the EMAR (Electronic Medication Administration Record) for all residents receiving blood glucose medications to ensure physician's orders are followed. Physicians were notified of any identified instances in which the physician orders were not followed related to blood glucose medications. 3. On 10/4/2022, the Director of Nursing and Asst. Director of Nursing began re-educating all licensed nursing staff on the requirement to ensure that physician orders related to blood glucose medications are followed and procedure for documenting when medications are held. 4. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool to monitor that physician orders related to blood glucose monitoring are followed five days per week for 4 weeks; then weekly for 4 weeks, then monthly. The QA tool will be completed for 6 months and until compliance is maintained by the Director of Nursing or designee. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. The facility, through the QAPI program, will review, update, and make	

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	- 09/03/22, the blood glucose was 81. The clinical record lacked documentation the medication had been held when the blood glucose was less than 90 in the morning. During an interview on 09/14/22 at 9:49 A.M., LPN (Licensed Practical Nurse) 4 indicated if a resident's medication had hold parameters, then the nurse would check the blood glucose level prior to administering the medication. The medication would be held if the blood glucose level was outside the parameters. She would then document in the EMAR or nurses note why the medication was held. During an interview on 09/19/22 at 12:45 P.M., the DON (Director of Nursing) indicated the resident should have had hold parameters in place for her metformin. The current facility policy, titled "Medication and Treatment Orders", with a revised date of July 2016, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...Orders for medications and treatments will be consistent with principals of safe and effective order writing..." The current facility policy, titled "Administering Medications", with a revised date of April 2019, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...Medications are administered in a safe and timely manner, and as prescribed...Medications are administered in accordance with prescriber orders, including any required time frames..." 3.1-48(a)(3)		changes to this plan of correction until 100% compliance is sustained for no less than six months.	

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be			

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	extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to follow a physician's order for a psychotropic medication for 1 of 6 residents reviewed for unnecessary medications. (Resident 65) Findings include: The clinical record for Resident 65 was reviewed on 09/14/22 at 1:31 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/03/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, hip fracture, and non-Alzheimer's dementia. A physician's order, dated 01/31/22 through 03/16/22, indicated the resident was to take Seroquel (an antipsychotic medication), 12.5 mg (milligrams) at bedtime. A telephone order, dated 03/16/22, indicated to increase the resident's Seroquel to 25 mg in the evening. The March 2022 EMAR (Electronic Medication Administration Record) indicated a physician's order, dated 03/16/22 through 03/28/22 for Seroquel 25 mg. Staff were to give the resident 12.5 mg at bedtime. The resident had received 12.5	F 0758	1. On 9/22/2022, the Director of Nursing notified resident 65's physician that the resident was administered the wrong dose of Seroquel from 3/16/22-3/28/22. 2. On 10/5/2022, the Dementia Program Director reviewed all telephone orders for psychotropic medications received in the past 3 months and the EMAR (Electronic Medication Administration Record) for all current in-house residents with orders for psychotropic medications to ensure physician's orders for psychotropic medications are followed. Physicians were notified of any identified instances in which the physician orders were not followed related to psychotropic medications. 3. On 10/4/2022 the Director of Nursing and Asst. Director of nursing began re-educating all licensed nursing staff on the requirement to ensure that physician orders related to psychotropic medications are followed and procedure for entering new orders received into the	10/07/2022

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	mg of the medication from 03/16/22 through 03/28/22, not the prescribed 25 mg. During an interview on 09/16/22 at 10:16 A.M., LPN (Licensed Practical Nurse) 2 indicated when the Nurse Practitioners would write new orders on a telephone order and the nurses would input the orders into the computer system. During an interview on 09/16/22 at 1:41 P.M., the DON (Director of Nursing) indicated, the resident was given the wrong dose of Seroquel from 03/16/22 through 03/28/22. It should have been 25 mg instead of the 12.5 mg. The current facility policy, titled "Medication and Treatment Orders", with a revised date of July 2016, was provided by the ADON (Assistant Director of Nursing) on 09/19/22 at 10:18 A.M. The policy indicated, "...Orders for medications and treatments will be consistent with principals of safe and effective order writing..." 3.1-48(a)(6)		computer system. The Dementia Coordinator or Designee will review all new telephone orders daily Mon-Friday to ensure that new orders for psychotropic medications are entered correctly into the computer system and administered per physician orders. 4. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance (QA) tool to monitor that new orders related to psychotropic medications are entered correctly into the computer system and administered per physician orders. The QA tool will be completed five days per week for 4 weeks; then weekly for 4 weeks, then monthly by the Director of Nursing or designee. The QA tool will be completed for 6 months and until compliance is maintained by the Director of Nursing or designee. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. The facility, through the QAPI program, will review, update, and make changes to this plan of correction until 100% compliance is sustained for no less than six months.	

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F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to follow the physician's order related to monitoring a blood glucose level prior to administration of diabetic medication for 1 of 6 residents reviewed for significant medication error. (Resident 60) Findings include: The clinical record for Resident 60 was reviewed on 09/13/22 at 3:01 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/31/22, indicated the resident was severely cognitively impaired. The diagnoses included but were not limited to, diabetes, depression, hypertension, and Alzheimer's disease. A Physician Progress Note, dated 07/25/22, indicated the resident's assessment and plan was to continue Metformin (a diabetic medication) 500 mg (milligrams), twice a day, and to hold the medication for a blood sugar that was less than or equal to 90. The September 2022 EMAR (Electronic Medication Administration Record) was reviewed and indicated the resident had an order for Metformin 500 mg at bedtime. The order lacked parameters to hold the medication if the blood sugar was less than or equal to 90. An Incident Progress Note, dated 09/06/22 at 7:24 P.M., indicated the residents blood glucose was 46. The resident was diaphoretic (excessive sweating) and had trouble arousing with	F 0760	1. Resident 60 no longer resides at the facility. 2. On 9/30/2022 the Director of Nursing reviewed the EMAR (Electronic Medication Administration Record) for all residents receiving blood glucose medications to ensure physician's orders are followed. Physicians were notified of any identified instances in which the physician orders were not followed related to blood glucose medications. 3. On 10/4/2022 the Director of Nursing and Asst. Director of Nursing began re-educating all licensed nursing staff on the requirement to ensure that physician orders related to blood glucose medications are followed and procedure for documenting when medications are held. 4. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance (QA) tool to monitor that physician orders related to blood glucose monitoring are followed five days per week for 4 weeks; then weekly for 4 weeks, then monthly. The QA tool will be completed for 6 months and until compliance is	10/07/2022

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	excessive sleepiness. The nurse administered Glucagon (treatment of low blood sugar) 1 mg (milligrams), subcutaneous, in the right lower abdomen. The resident's blood sugar was rechecked and was 58. The nurse had went to obtain another dose of glucagon from the emergency drug kit, she rechecked the resident blood glucose and it was 76. She did not administer a second dose of glucagon. The resident then became awake but lethargic. The resident was able to consume some orange juice. The resident had complaints of being tired and lethargic. The physician was made aware. A Medication Administration Audit Report, was provided by the ADON (Assistant Director of Nursing) on 09/19/22 at 11:14 A.M. The report indicated the resident had received her bedtime Metformin on 09/06/22 at 6:47 P.M., and her glucose was checked at 7:39 P.M. During an interview on 09/14/22 at 9:49 A.M., LPN (Licensed Practical Nurse) 4 indicated if a resident's medication had hold parameters, then the nurse would check the blood glucose level prior to administering the medication. The medication would be held if the blood glucose level was outside the parameters. She would then document in the EMAR or nurses note why the medication was held. During an interview on 09/19/22 at 12:40 P.M., Nurse Practitioner 8 indicated the residents Metformin would not drop the residents blood glucose as much as her Levemir (an blood glucose medication) would, but she wanted to give hold parameters on the medications due to the resident had not been eating well and had a significant decline in her health.		maintained by the Director of Nursing or designee. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. The facility, through the QAPI program, will review, update, and make changes to this plan of correction until 100% compliance is sustained for no less than six months.	

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	During an interview on 09/19/22 at 12:45 P.M., the DON (Director of Nursing) indicated the resident should have had hold parameters in place for her Metformin medication. The current facility policy, titled "Medication and Treatment Orders", with a revised date of July 2016, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...Orders for medications and treatments will be consistent with principals of safe and effective order writing..." The current facility policy, titled "Adverse Consequences and Medication Errors", with a revision date of April 2014, was provided by the ADON on 09/19/22 at 10:18 A.M. The policy indicated, "...Residents receiving and medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported... A "medication error" is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principals of the professional(s) providing services..." 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals			

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	§483.45(h)(1) 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. §483.45(h)(2) 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 store medications appropriately related to labeling medications in 2 of 4 medication carts and for 1 of 4 medication rooms reviewed for medication storage and labeling. (Unit 3 medication cart, Unit 4 medication cart, and Unit 3 medication room) Findings include: 1. A medication cart on the Unit 3 was observed on 09/12/22 at 10:27 A.M., with LPN (Licensed Practical Nurse) 5, and contained the following medications: - A bottle of Refresh Tears was 1/2 full with no opened date for Resident 20, - A tube of Erythromycin 5 mg/gm (milligram per gram) antibiotic ointment was 1/2 full with no opened date for Resident 10, - A bottle of latanoprost solution 0.005% eye drops was less than 1/2 full with no opened date	F 0761	1. On 9/19/2022 the Director of Nursing discarded the identified medications for Resident 20, 10, 41, 34, and 35 that were not labeled with opened date and replacement medications were obtained and labeled with opened dates. On 9/12/22, the bottle of Aplisol in the medication refrigerator with opened date of 8/8/22 was discarded. 2. On 10/3/2022 the Director of Nursing conducted an observation of all medication carts and medication rooms in the facility to ensure that all medications are stored and labeled appropriately. Any medications that were not appropriately labeled or stored were discarded and replaced. 3. On 10/4/2022 the Director of Nursing and Asst. Director of	10/07/2022

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	for Resident 41. 2. The medication room refrigerator on Unit 3 was observed on 09/12/22 at 10:29 A.M., with LPN 5. The refrigerator contained a bottle of Aplisol (tuberculin [TB] solution) less than 1/4 full with an opened date of 08/08/22. 3. A medication cart on the Unit 4 was observed on 09/19/22 at 2:10 P.M., with RN 6, and contained the following medications: - A bottle of Refresh Tears 0.5% eye drops was 3/4 full with no opened date for Resident 34, - A bottle of ciprofloxacin 0.3% eye drops was 1/2 full with no open date for Resident 35. During an interview on 09/19/22 at 02:12 P.M., RN 6 indicated there should be an opened date on medications to identify when the medication was opened. During an interview on 09/19/22 at 3:14 P.M., the DON (Director of Nursing) indicated medications should have an opened date and the Aplisol was only good for 30 days once it was opened. No resident had received the Aplisol after 09/07/22. The Aplisol package insert was provided by the DON on 09/19/22 at 3:10 P.M., indicated "...Aplisol vials should be inspected visually for both particulate matter and discoloration prior to administration and discarded if either is seen. Vials in use for more than 30 days should be discarded..." The current Administering Medications Policy, with a revised date of April 2019, was provided by the DON on 09/19/22 at 3:10 P.M. The policy indicated, "...The expiration/beyond use date on		Nursing began re-educating all licensed nursing staff on the requirement to ensure that all medications in multi-dose containers are appropriately labeled with date opened and discarded based upon manufacturer instructions and/or facility policy. 4. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool to monitor that medications in multi-dose containers are labeled with date opened and discarded based upon manufacturer instructions and/or facility policy. The QA tool will be completed by the Medical Records Coordinator five days per week for 2 weeks; then weekly for 4 weeks, then monthly. The QA tool will be completed for 6 months and until compliance is maintained by the Director of Nursing or designee. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. The facility, through the QAPI program, will review, update, and make changes to this plan of correction until 100% compliance is sustained for no less than six months.	

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	the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container..." 3.1-25(j) 3.1-25(o)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on record review and interview, the facility failed to follow a physician's order related to a laboratory test for 1 of 19 residents reviewed for laboratory services. (Resident 14) Findings include: The clinical record for Resident 14 was reviewed on 09/13/22 at 2:28 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/24/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia, hyponatremia, and hyperlipidemia. An open-ended physician's order, with a revision date of 02/01/21, indicated the resident was to have a lipid profile, yearly in July, for hyperlipidemia. The resident's laboratory results from June 2022	F 0770	1. On 9/19/2022 the Director of Nursing notified Resident 14's physician that the Lipid profile ordered to be completed yearly in July was not obtained in July 2022. A new order was received to draw a Lipid profile and was obtained on 9/20/22. 2. On 10/3/2022 the Asst. Director of Nursing reviewed all active physician orders related to laboratory tests and medical records of all current in-house residents to ensure that all laboratory tests were obtained per physician orders. Physicians were notified on any identified missing laboratory results. 3. On 10/4/2022 the Director of Nursing and Asst. Director of Nursing began re-educating all	10/07/2022

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	09/19/2022

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
	through September (current) were provided by the DON (Director of Nursing) on 09/16/22. The laboratory results lacked a lipid profile. During an interview on 09/16/22 at 1:42 P.M., the DON indicated the resident should have had a lipid profile completed in July per the physician's order. The current facility policy, titled "Lab and Diagnostic Test Results-Clinical Protocol", with a revised date of November 2018, was provided by the ADON (Assistant Director of Nursing) on 09/19/22 at 10:18 A.M. The policy indicated, "...The staff will process test requisitions and arrange for tests..." 3.1-49(a)		licensed nursing staff on the requirement to ensure that all laboratory tests are obtained per physician orders. A Lab Tracking sheet was implemented on 10/5/2022 to track completion of ordered laboratory testing. 4. The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool to monitor that laboratory tests are completed per physician orders. The QA tool will be completed by the Asst. Director of Nursing five days per week for 2 weeks; then weekly for 4 weeks, then monthly. The QA tool will be completed for 6 months and until compliance is maintained by the Director of Nursing or designee. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. The facility, through the QAPI program, will review, update, and make changes to this plan of correction until 100% compliance is sustained for no less than six months	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and	R 0000		

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	State Licensure Survey and the Investigation of Complaint IN00385278. Complaint IN00385278 - Unsubstantiated due to lack of evidence. Survey dates: September 12, 13, 14, 15, 16, and 19, 2022 Facility number: 000420 Residential Census: 19 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 September 27, 2022.			