STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155730	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ripley Crossing	1200 Whitlatch Way Milan, IN 47031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50498 Based on observation and record review, the facility failed to ensure a resident was treated with respect and dignity for 1 of 5 residents reviewed for resident rights. (Resident F) Findings include: During an observation on 09/23/24 at 8:48 A.M., CNA (Certified Nurse Aide) 3 was observed standing beside Resident F's bedside and the CNA stated, I'm not dealing with people telling me to shut up . Well then someone else can deal with you then! and then exited the resident's room into the community living room. The CNA noticed she was being observed, then she turned around and walked back into Resident F's room and began asking what the resident would like to wear today. During an interview with Resident F on 09/23/24 at 12:59 P.M., she indicated that some of the staff are mean to her, but she can't remember their names. They come into her room and say what she needs to do in a nasty way. During an interview on 09/23/24 at 1:09 P.M., LPN (Licensed Practical Nurse) 4 indicated that Resident F was pretty alert and that she talked to family daily. Resident F has dementia, but it was more of a short-term memory issue. She talked about her home land and her children regularly with staff. The clinical record for Resident F was reviewed on 09/23/24 1:57 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/01/24, indicated the resident was severely cognitively impaired. The diagnosis included, but were not limited to, anemia, heart failure, and non-Alzheimer's dementia. A current facility policy titled Dignity, provided by the Administrator on 09/23/24 at 1:58 P.M., with a revision date of February 2021, stated .Each Resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self worth and self-esteem ., . Residents are treated with dignity and respect at all times . 3.1-3(t)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155730	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ripley Crossing	1200 Whitlatch Way Milan, IN 47031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 50498 Based on record review and interview, the facility failed to ensure misappropriation of resident's medications did not occur for 3 of 5 residents reviewed for misappropriation. (Residents B, D, and E) Findings include: 1.The clinical record for Resident B was reviewed on 09/20/24 9:48 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 8/13/24, indicated the resident was cognitively intact. The diagnosis included, but were not limited to, anxiety and depression. A current physician's order, with a start date of 12/05/22, indicated the staff were to administer Norco (a pain medication), 5-325 mg (milligrams), 1 tablet by mouth every six hours as needed for pain. A controlled drug record for Resident B, dated 07/12/24, shows documentation for the resident's Norco medication being signed out by RN (Registered Nurse) 2 on 08/25/24 at 8:00 A.M. and at 2:00 P.M. The facility as worked schedule, provided by the Administrator on 09/23/24 at 11:30 A.M., showed that RN 2 was not working on 08/25/24. The electronic medication administration record (EMAR) for Resident B on 08/25/24 showed the medication was only administered at 8:00 P.M. by a second shift nurse. During an interview with resident B, on 08/20/24 at 8:42 A.M., she indicated that she had an order for Norco if she had pain, but she did not like to take it because it made her feel sick and loopy. It had been months since she had taken one and she had only taken one then at night because she can sleep it off. During an interview with the Assistant Director of Nursing (ADON) on 09/23/24 at 9:21 A.M., she indicated that they noticed on 08/27/24 that RN 2 had signed out medications on 08/25/24 when they were not scheduled. The Director of Nursing (DON) and ADON met with RN 2 asking if there was a reason they signed out medications for a day they were not scheduled. RN 2 admitted ,at that time, of taking the medications home. A facility document provided by the ADON on 09/20/24 at 2:23 P.M. labeled Employee Counseling Record Form indicated that RN 2 was discharged from the facility for misappropriation of resident property on 08/27/24. 2. The clinical record for Resident D was reviewed on 09/23/24 9:45 A.M. An Annual MDS (Minimum Data Set) assessment, dated 06/29/24, indicated the resident was severely cognitive impaired. The diagnosis included, but were not limited to, non-traumatic brain dysfunction, Alzheimer's disease, anxiety, and depression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155730	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ripley Crossing	1200 Whitlatch Way Milan, IN 47031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order for Resident D, with a start date of 10/27/23, indicated that staff were to administer Percocet (a pain medication), 5-325 mg (milligrams), 1 tablet by mouth every twelve hours as needed for breakthrough pain. A controlled drug record for Percocet for Resident D showed documentation for the medication being signed out by RN 2 on 08/22/24 at 4:00 P.M. The facility as worked schedule, provided by the Administrator on 09/23/24 at 11:30 A.M., showed that RN 2 was not working on 08/22/24. The electronic medication administration record for resident D on 08/22/24 showed the medication was only administered at 3:02 P.M. by the nurse scheduled to care for the resident that day. 3. The clinical record for Resident E was reviewed on 09/23/24 2:21 P.M. An Annual MDS (Minimum Data Set) assessment, dated 06/20/24, indicated the resident was moderately cognitive impaired. The diagnosis included, but were not limited to, Alzheimer disease, hypertension, and atrial fibrillation. A physician's order for resident E, with the state date of 12/12/23, indicated that staff were to administer Norco (a pain medication), 5-325 mg (milligrams), 1 tablet by mouth every eight hours as needed for pain. A controlled drug record for Resident E, showed documentation for the Norco medication being signed out by RN 2 on 08/18/24 at 10:00 A.M., 08/20/24 at 1:30 P.M., and on 08/21/24 at 9:30 A.M. The electronic medication administration record for resident E showed the medication was not administered at any time on 08/17/24, 08/20/24, or 08/21/24. The current facility policy titled, Abuse and Neglect, dated August of 2018, was provided by the Administrator on 09/23/24 at 1:58 P.M. The policy indicated, .The facility will identify events, occurrences, patterns, and trends that may constitute .misappropriation of property . The deficient practice was corrected on 08/27/24 after the facility reviewed records, assessed residents, and educated staff on misappropriation of medication. The facility discharged RN 2 for misappropriation of resident's property. This Citation relates to Complaint IN00441965 3.1-28(a)