

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER Ripley Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50498</p> <p>Based on observation, interview, and record review, the facility failed to follow infection control guidelines during a dressing change and touching the floor related to hand hygiene for 1 of 4 residents reviewed for infection control. (Resident B)</p> <p>Findings include:</p> <p>During an observation, on 03/10/25 at 9:26 A.M., RN (Registered Nurse) 3 preformed hand hygiene and donned a gown and gloves to begin a wound dressing change on Resident B. She began removing the dressing from Resident B's right breast. The dressing was saturated upon removal. An egg sized wound was visualized on Resident B's right breast. A piece of the gauze, fully saturated in drainage, fell on to the floor. RN 3 picked up the saturated gauze off the floor and discard it with the used dressing in a bag. RN 3 then began cleaning the resident's wound. No hand hygiene was completed or removal of gloves. After cleansing the wound RN 3 began applying the new dressing to Resident B's right breast. RN 3 proceeded to a second dressing change on Resident B's right foot. No hand hygiene was completed in-between dressings or after picking up soiled gauze off the floor. The RN removed the dressing and cleansed the resident's right heel wound with cleanser, patted it dry, and then applied the new dated dressing. No hand hygiene was observed.</p> <p>The clinical record for Resident B was reviewed on 03/10/25 at 10:07 A.M. A Quarterly Minimal Data Set (MDS) assessment, dated 12/22/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, anemia, and cancer.</p> <p>A Progress Note, dated 10/27/23 at 2:04 P.M., indicated that Resident B was complaining of right breast pain. Upon an assessment it was swollen and tender to touch with a hard area noted. Resident B had a diagnosis of malignant neoplasm of the right breast. The family indicated that Resident B had refused treatment, and that the area flares up from time to time and will burst open and bleed. The area can get as large as a baseball during flare ups.</p> <p>A current physician's order, with a start date of 01/20/25, indicated the staff were to cleanse the wound to the right breast with wound cleanser, pat dry, apply petroleum jelly gauze, and apply a foam adhesive dressing every day and as needed for wound soilage/dislodgement.</p> <p>A current physician's order, with a start date of 11/12/24, indicated to staff were cleanse right heel with wound cleanser, pat dry, and apply a foam adhesive dressing every 3 days and as needed for soiled/dislodgement.</p> <p>(continued on next page)</p>		

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
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/10/25 at 1:52 P.M., Licensed Practical Nurse (LPN) 2 indicated that after removing a dressing she would dispose of it and immediately perform hand hygiene. She would put on new gloves before cleaning and applying the new dressing. She would never touch the floor and then touch a wound. If she were to touch the floor during a dressing change, she would perform hand hygiene and don new gloves.</p> <p>The current facility policy, with a revision date of 08/15/22, titled Standard Precautions Infection Control was provided by the Director of Nursing (DON) on 03/10/25 at 2:15 P.M. The policy indicated, .a. During the delivery of resident care services, avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces .</p> <p>The current facility policy, with a revision date of September 2013, titled Dressings, Dry/Clean was provided by the Director of Nursing (DON) on 03/10/25 at 2:15 P.M. The policy indicated, .6. Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. 9. Open dry dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. 10. Label tape or dressing with date, time and initials. Place on clean field. 11. Using clean technique, open other products (i.e., prescribed dressing; dry, clean gauze). 12. Wash and dry your hands thoroughly. 13. Put on clean gloves. 14. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage. 15. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward). 16. Use dry gauze to pat the wound dry. 17. Apply the ordered dressing and secure with tape or bordered dressing per order .Label with date and initials to top of dressing .</p> <p>This citation relates to Complaint IN00454176.</p> <p>3.1-18(a)</p>		