

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 12/16/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow appropriate safety measures when assisting a resident in their wheelchair, resulting in the resident falling and sustaining injuries that required hospitalization for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: A Health Status Note, dated 09/08/2025 at 11:17 A.M., indicated a nurse was pushing the resident in his wheelchair up to the front lobby to leave for a dialysis treatment. The resident's feet fell to the floor causing the resident to fall forward out of the wheelchair. The resident fell face first onto the floor and immediately began to bleed from the nose. The resident was assessed for injuries, and his nose was bleeding a large amount. Pressure was applied to the resident's nose, and the resident was assisted by two staff members to a sitting position back into the wheelchair. Staff applied ice and pressure to the bridge of the resident's nose. The facility Nurse Practitioner was notified, and the resident was sent to the local hospital for evaluation and treatment. The Hospital Discharge summary, dated [DATE], indicated the following: The resident was admitted to the hospital on [DATE] following a fall from his wheelchair resulting in facial trauma and epistaxis (nosebleed). On admission, the resident was found to have a nasal fracture and septal fracture. Evaluation revealed both anterior and posterior epistaxis, that was initially controlled. During the hospitalization, the resident experienced recurrent episodes of packing dislodgement and breakthrough bleeding, necessitating repeat interventions that included replacement of packing and ultimately the placement of Surgi Flo (an absorbable gelatine paste used in surgery) packing. The packing was removed on 09/15/2025, and no further bleeding was observed. The resident received antibiotics for sinusitis prophylaxis (as a preventative measure). Throughout the admission, the resident was managed with limb restraints due to agitation and repeated attempts to remove nasal packing and oxygen devices, with intermittent confusion and agitation noted. The resident's hospital course was complicated by anemia requiring blood transfusions, with hemoglobin levels trending down and subsequently improving after transfusion and adjustment of the resident's dialysis regimen. Other chronic issues were addressed during the admission, and by 09/16/2025, all nasal packing had been removed. The resident was discharged with plans for outpatient clinical follow up. A Fall Care Plan, initiated on 11/13/2023, indicated the resident was at risk for falls related to weakness due to chronic obstructive pulmonary disease and end stage renal disease with hemodialysis. The interventions included, but were not limited to, a current intervention, with a start date of 11/13/2023, to assist the resident with transfers as needed. The Fall Care Plan was updated, on 09/09/2025, with an intervention to ensure foot pedals were used on the wheelchair when the wheelchair was propelled by staff. Staff were to remove the foot pedals when arriving at the destination due to the resident being able to propel himself in the wheelchair. During an interview, on 12/15/2025 at 10:10 A.M., Licensed Practical Nurse (LPN) 6 indicated she was pushing the resident in his wheelchair to the front lobby to meet his ride for dialysis. They stopped at the rug near the door. The resident's ride was outside, so she started to push the wheelchair again and the resident fell forward. The resident's feet skidded on the rug and he fell forward. It happened very fast. The resident always used the wheelchair, especially for longer distances like to the front of the building. He could propel himself short distances, but not long distances. She didn't put foot pedals on the wheelchair prior to pushing him to the lobby. If a res was non-ambulatory, leg rests/foot pedals would be in place on the wheelchair for positioning. Residents that propelled themselves to some degree may not have foot pedals on their wheelchair. The resident went to the hospital and was there for a few days. During an interview, on 12/15/2025 at 9:58 A.M., the Therapy Department Manager (TDM) indicated the resident was participating in therapy prior to the fall on 09/08/2025. At the time of the fall, the resident required moderate to maximum staff assistance with transfers and Activities of Daily Living (ADLs). He had been up walking with the rollator (walker), but as he got sicker, he was using the wheelchair more frequently. At the time of the fall, he could propel himself short distances in the wheelchair. Leg rests/foot pedals should be in place when staff were pushing residents in their wheelchairs regardless of the distance the resident was being pushed. She would recommend the foot pedals be in place while the resident was being propelled in the wheelchair by a staff member. She would recommend staff remove the foot pedals if the resident was just sitting in their wheelchair in their room or something because most residents could not remove the foot pedals on their own and that could be a fall risk. The current facility policy, titled Accidents and Supervision, dated 09/01/2022, was provided by the Director of Nursing (DON) on 12/15/2025 at 12:37 P.M. The policy indicated The</p>		