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	12/16/2025

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 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. **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 subsequentially 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 (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 resident environment will remain free of accident hazards as is possible.The current, undated facility policy, titled Policy and Procedure: Use of a wheelchair, was provided by the DON on 12/15/2025 at 12:37 P.M. The policy indicated, .Proper use of a wheelchair .Determine if a resident can self-propel .if not, ensure foot pedals are in place .This citation relates to Intakes 2611892 and 2666336.3.1-45(a)(2)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to notify the physician of a change in a resident's condition for 1 of 20 residents reviewed for notification of change. (Resident 82)Findings include:The clinical record for Resident 82 was reviewed on 12/11/2025 at 10:04 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 10/23/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, diabetes, depression, respiratory failure, and food in the respiratory tract. A Progress Note, dated 09/22/2025 at 8:30 A.M., indicated the nurse was called to the dining room by a Certified Nurse Aide (C NA) who reported the resident was choking. The Heimlich maneuver was attempted when the resident's face went pale in color. After three to five attempts, the resident began talking and color returned to her face. The resident eventually coughed up a soggy piece of waffle. The Assistant Director of Nursing (ADON) was called to the unit to help assess the resident. The resident's Power of Attorney (POA) was notified. The clinical record lacked documentation the physician was notified of the choking incident on 09/22/2025.During an interview, on 12/12/2025 at 11:10 A.M., RN 2 indicated if a resident had choked on their food, she would assess the resident and determine if the Heimlich maneuver needed to be initiated. After the resident was deemed safe, the family and physician would be notified. She would also notify the speech therapist. She would document in a Progress Note the event details and that the family and physician were notified.During an interview, on 12/12/2025 at 3:15 P.M., the Director of Nursing (DON) indicated she remembered talking to the Nurse Practitioner (NP) about the resident choking but there was no documentation the NP was notified after the resident choked on 09/22/2025. The current facility policy titled, Change in a Resident's Condition or Status with a revision date of 2021, was provided by the DON on 12/15/2025 at 12:37 P.M. The policy indicated, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .3.1-5(a)(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to identify a pressure ulcer in a timely manner for 1 of 3 residents reviewed for pressure ulcers. (Resident 1) Findings include:During an interview and observation, on 12/11/2025 at 10:25 A.M., RN 7 indicated Resident 1 had a pressure ulcer on her coccyx. The resident was sitting in their wheelchair and refused to be transferred to bed for the wound to be observed further.The clinical record for Resident 1 was reviewed on 12/12/2025 at 1:20 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/03/2025, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, anemia, hypertension, heart failure, pneumonia, dementia, and schizophrenia. The resident was dependent on staff for personal hygiene and transfers.The current physician's order, with a start date of 08/06/2024, indicated the resident was to have weekly skin assessments completed on every Wednesday. The weekly skin assessments, for July 1 through August 3, 2025 indicated the resident had no new skin concerns. A Weekly Wound Observation Tool , dated 08/04/2025, indicated the resident had a Deep Tissue Injury (DTI) on her sacrum measuring 45 millimeters (mm) x (by) 20 mm. This was the first documented finding of the resident's new skin condition.A Weekly Wound Observation Tool, dated 08/06/2025, indicated the sacrum wound was now described as an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer was covered by slough).The Wound Doctor's Note, dated 08/12/2025, indicated the wound was an unstageable DTI on her sacrum measuring 5 centimeters (cm) x 3 cm with intact skin. A Quarterly MDS assessment, dated 08/26/2025, indicated the resident had a deep tissue injury (purple or maroon discolored skin) on her sacrum.The clinical record lacked documentation to indicate the resident's sacrum wound was identified prior to being found with necrotic tissue and moisture. During an interview, on 12/15/2025 at 2:09 P.M., Certified Nurse Aide (CNA) 5 indicated Resident 1 refused care at times. Prior to the DTI developing, a barrier cream was applied to the resident's buttocks. When a new skin area was found the nurse would be notified. The resident was verry weak and sick at the end of summer. During an interview, on 12/12/2025 at 12:36 P.M., the Nurse Practitioner (NP) indicated the resident had a wound on her sacrum that developed rapidly in August. At that time, the resident was very ill with pneumonia, was eating small amounts, and was refusing to be turned. During an interview, on 12/16/2025 at 10:10 A.M., the Director of Nursing (DON) indicated the resident had been very ill with pneumonia in August. She had developed a wound on her sacrum that was first observed on 08/04/2025. The wound doctor was consulted. The resident was refusing to be turned, to get out of bed, and was refusing to eat at times. She had been offered supplements but, refused those. The wound developed quickly related to the resident's overall poor condition. The current facility policy Prevention of Pressure Injuries, dated April 2020, was provided by the DON on 12/15/2025 at 12:37 P.M. The policy indicated .Inspect the skin on a daily basis when preforming or assessing with personal care or ADLs (Activities of Daily Living). Identify any signs of developing pressure injuries.3.1-40(a)(1)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure proper placement of urinary catheter tubing and drainage bag for 1 of 3 residents reviewed for urinary catheters . (Resident 37) Findings include:On 12/09/2025 at 11:55 A.M., Resident 37 was observed sitting in her recliner in her room. She had recently finished working with therapy in her room. The urinary catheter drainage collection bag was hanging from the side of the recliner with three inches of the bag touching the floor. On 12/09/2025 at 1:57 P.M., Resident 37 was sitting in her recliner in her room. The urinary catheter drainage bag was hanging from the side of the recliner with three inches of the bag touching the floor. During an interview on 12/15/2025 at10:14 A.M., Certified Nurse Aide (CNA) 3 indicated the urinary catheter collection bag should be hung lower than the resident's bladder and not touching the floor. The resident needed assistance transferring from the bed to the recliner. An admission Minimum Data Set (MDS) assessment, dated 11/24/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, hip fracture, end stage renal disease, hypertension, diabetes, and urinary tract infection in the last 30 days. The resident had an indwelling urinary catheter. The resident required assistance from staff for transfers. The current facility policy, titled Catheter Care, Urinary, dated September 2014, was provided by the Director of Nursing (DON) on 12/15/2025 at 12:37 P.M. The policy indicated, .Be sure the catheter tubing and drainage bag are kept off the floor.3.1-18(b)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to appropriately store medications for 1 of 3 medication carts reviewed. (Wing 2 Medication Cart)Findings include: On [DATE] at 2:52 P.M., the Wing 2 Medication Cart was observed with RN 3. The Medication Cart contained a 1/4 full Humalog insulin pen for Resident 10. A sticker indicated the pen was opened on [DATE] and should be discarded by [DATE]. During an interview, on [DATE] at 2:53 P.M., RN 3 indicated the resident received insulin every day before meals. RN 3 used the pen to administer insulin to the resident before breakfast and before lunch that day. The resident probably got insulin from it yesterday too. The medication was expired and should have been discarded on [DATE].The current facility policy, titled Storage of Medications, with a revision date of [DATE], was provided by the Assistant Director of Nursing on [DATE], at 2:49 P.M. The policy indicated, .facility stores all drugs and biologicals in a safe, secure, and orderly manner.Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.3.1-25(o)