STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robin Run Health Center	6370 Robin Run W Indianapolis, IN 46268

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38767 Based on observation, interview, and record review, the facility failed to care for a resident in a manner that preserved the resident's dignity and rights for 1 of 3 residents reviewed for quality of care (Resident K). Findings include: During an interview on 4/24/24 at 3:31 p.m., a family member indicated the family would get upset when they visited and Resident K did not out of bed every day in the morning. The family had requested the resident be out of bed in the morning and be laid down in the afternoon, therefore being up approximately 4 hours daily which would accommodate him being taken to activities. The family was also unhappy when the resident was in bed and dressed only in a T-shirt or gown and adult brief. The resident tended to be cold and family members had provided thermal tops and pajama bottoms so he would stay warm. During the last care plan meeting the family had been promised the staff would get the resident out of bed daily from around 11:00 a. m., - 3:00 p.m. daily, he loved to attend activities, liked music, and to play checkers. Observations of the resident in bed not involved in activities on 4/24/24, a. At 3:23 p.m., the resident was lying on his back in the bed with eyes open, personal quilt on bed covering him up to his chin, wearing a hospital gown. Observations of the resident in bed not involved in activities on 4/25/24, a. At 11:03 a.m. the resident was lying on his back in the bed, wearing a hospital gown, quilt up to his chin. The resident indicated he preferred to be out of bed daily, it had been 3 days since he had been gotten up. b. At 12:52 p.m., the resident was lying on his back in the bed watching TV, wearing a hospital gown. Qualified Medication Aide (QMA) 13 indicated the resident was gotten out of bed daily when his tube feeding was done. QMA 13 indicated she could not explain why the resident had not been seen out of bed on the day shift this week. c. At 2:43 p.m., the resident was lying on his back in the bed with the quilt pulled over his head. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. At 3:39 p.m., the resident was lying in bed on his back, awake, wearing a hospital gown. Observations of the resident in bed not involved in activities on 4/26/24, a. At 12:02 p.m., the resident was lying on his back in the bed, awake, wearing a hospital gown, quilt from head to toe on right side of body, mid body and left side uncovered. Resident K indicated he had not been gotten out of bed this week, had wanted to be up. g. At 1:32 p.m., the resident was lying on his back in bed with his head on a pillow. Certified Nursing Assistant (CNA) 22 indicated she routinely worked the resident's hallway on day shift. Staff usually got Resident K out of bed after his tube feeding had been disconnected around 1:00 p.m. as he liked to roam in his wc. However, it was difficult for staff to get the resident out of bed around 1:00 p.m. as they were still serving lunch at that time. She did not know what happened this week and why the resident had not gotten out of bed. Observations of the resident in bed not involved in activities on 4/29/24, a. At 11:30 a.m., the resident was on his back in the bed, wearing a hospital gown. Resident K's record was reviewed on 4/26/24 at 1:39 p.m. Diagnoses on Resident K's profile included, but not limited to, hemiplegia, and hemiparesis (paralysis on one side of the body) on left non-dominant side, dysphagia (difficulty with communication to include speaking). A Quarterly/Annual Activities Participation Review, dated 11/20/23, indicated Resident K attended social events, bingo, movies, exercise, and art. The resident's favorite activities, special accomplishments, and/or new interests included bingo and social events. The resident's mother attended some programming with him also. Social Service Director (SSD) provided documentation, a. A care plan conference summary, dated 11/8/23, the family requested to have resident layered in clothing due to change in weather. b. A SSD note, dated 1/26/24, the spouse came in to office with a daughter on the cell phone speaker. My daughter was asking questions about the residents g-tube. c. A care plan conference summary, dated 4/18/24, care plan scheduled for 4/18/24, family was a no show. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan indicated Resident K had impaired cognitive function, his family visited and family stated he liked to watch TV and sports and play cards, he could comprehend commands with yes and no jesters, he would benefit from associate support for activity participation related to interest for cognitive, social and emotional fulfillment/stimulation in group/one on one settings. The goal was for the resident to maintain involvement in activities for cognitive, emotional and social fulfillment in guided groups/one on ones. Interventions included to invite the resident to scheduled programming and provide a calendar of events and welcome by name. Provide support necessary to maximize success in programming such as cueing and assistance with crafts and games. Work in concert with family to identify supplies that can be provided to enhance their visit and activity participation within group or one on one (1:1). During an interview on 4/29/24 at 10:02 a.m. Nurse Practitioner (NP) 20 indicated she was in the facility 4 days per week, she had not seen Resident K out of the bed in the last week. The resident liked to be up around others and interacting. He cared a lot about his appearance, i.e. what clothing he was wearing, and he would spend a lot of time picking out a hat for any occasion. NP 20 indicated she felt the resident was most comfortable when he was up out of bed. He was a proud veteran and liked it when others acknowledged it, he liked to flirt, and be told he was [NAME]. This Federal tag relates to Complaints IN00432486 and IN00433009. 3.1-3(u)(1)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 38767 Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for 3 of 3 dependent residents observed for call light placement (Residents M, P, and Q). Findings include: 1. During a random observation on 4/25/24 at 10:57 a.m., Resident M was observed sitting in a wheelchair (wc) at the end of her bed, the call light cord was pulled out of the wall and laying on the bed out of the resident's sight. The resident indicated that she could not see and was transferred out of the bed and propelled around in her wc by the staff. On 4/25/24 at 11:23 a.m., a 2nd observation of Resident M sitting in a wc at end of her bed, the call light remained unplugged from the wall and lying on the bed. Observation of 2 unidentified Certified Nursing Assistants (CNA's), Registered Nurse (RN) 6, and the Director of Nursing (DON) walking by the resident room on the hallway, no one addressed the call light which was visible from the hallway. On 4/25/24 at 12:30 p.m., a 3rd observation of Resident M sitting in a wc at the end of her bed conversing with a relative, the call light remained unplugged from the wall and lying on the bed. CNA 10 and Qualified Medication Aide (QMA) 13 indicated the resident used her call light to get assistance, they were unaware the call light was out of the wall. Resident M's record was reviewed on 4/26/24 at 9:30 a.m. Diagnoses on Resident M's profile included, but were not limited to, zoster ocular disease (disorder caused by the varicella-zoster virus that resulted in loss of vision, a history of falls, and dementia. An annual MDS (Minimum Data Set) assessment and a State Optional assessment, both completed on 3/6/24, assessed Resident M as having the ability to make herself understood and sometimes understand others. Her vision was severely impaired. A BIMS (brief interview for mental status) score 12/15 indicated moderate cognitive impairment. The resident required extensive assistance of one person physical assist for bed mobility, transfers, and toilet use. Mobility devices included a wheelchair. A care plan indicated Resident M was at risk for falls related to decline in function, ocular zoster, and diagnosis of bilateral knees osteoarthritis. The goal was for the resident not to have falls resulting in serious injury through the review date. Interventions included be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, and routine room monitoring. 2. On 4/25/24 at 12:45 p.m., Resident P was observed lying on her back in the bed, a quilt pulled over her head, the call light was tucked underneath her right shoulder out of her sight. CNA 10 indicated the resident was capable of using her call light to call for assistance, she was not able to transfer and ambulate independently. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident P's record was reviewed on 4/26/24 at 9:52 a.m. Diagnoses on Resident P's profile included, but were not limited to, vision loss, a history of falls, and dementia. An annual MDS assessment and a State Optional assessment, both completed on 2/4/24, assessed Resident P as having the ability to make herself understood and usually understand others. Her vision was severely impaired. A BIMS score 5/15 indicated severe cognitive impairment. The resident required extensive assistance of one person physical assist for bed mobility, and she was totally dependent with one person physical assist for transfers, and toilet use. Mobility devices included a wheelchair. A care plan indicated Resident P was at risk for falls related to vision problems and preference to have blankets covering her head. The goal was for the resident to be free from falls and not sustain serious injury through the next review date. Interventions included be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed a prompt response to all requests for assistance. 3. On 4/25/24 at 11:11 a.m., Resident Q was observed sitting in a wc at the end of her bed watching television (TV). A call light was observed under the bedding at the top of the bed, out of sight and reach of the resident. The resident indicated if she needed the nurse she would push her button, and then was observed to look around the sides of her wc and state she could not find it. Resident Q's record was reviewed on 4/26/24 at 10:03 a.m. Diagnoses on Resident Q's profile included, but were not limited to, a history of falling, hemiplegia, and hemiparesis (paralysis on one side of the body) on the left non-dominant side following a cerebral infarction (stroke), and dementia. A quarterly assessment and a State Optional assessment, both completed on 1/20/24, assessed Resident Q as having the ability to make herself understood and usually understand others. A BIMS score 15/15 indicated cognitively intact. The resident was totally dependent on one person physical assist for bed mobility, transfers, and toilet use, mobility devices included a wheelchair. The resident had one fall since the previous assessment. A care plan indicated Resident Q was at risk for falls related to immobility. The goal was for the resident to be free from falls and not sustain any serious injury through the review date. Interventions included making sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, and routine room monitoring. On 4/29/24 at 3:10 p.m., the Administrator (ADM) provided an Answering the Call Light policy, dated April 16, indicated the policy was the one currently being used by the facility. The policy indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs .4. Be sure that the call light is plugged in and functioning at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident . This Federal tag relates to Complaint IN00432282. 3.1-3(v)(1)

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 38767 Based on observation, and interviews, the facility failed to publicly post the name, address, and telephone number of the area Ombudsman (resident advocate who provided information on quality care and helped to resolve problems in the nursing home). This deficient practice affected 44 of 44 residents residing in the facility and/or the residents' representatives. Findings include: A confidential interview conducted during the survey indicated they wanted the Ombudsman to visit residents on a regular basis, but had not seen a posting of the Ombudsman's contact information for resident or family use. On 4/25/24 at 12:19 p.m., during an observation of the front entrance and common areas of the health center indicated there was no posting of contact information for the area Ombudsman. Staff interviews regarding the availability and location of Ombudsman information in the health center, a. Registered Nurse (RN) 6 indicated she knew that it was a requirement to have the Ombudsman information handy, but she had not seen it posted. b. The Assistant Director of Nursing (ADON) indicated this was her 5th day and she did not know where the information was posted. c. The Director of Nursing (DON) indicated she did not know where the information was posted. d. Receptionist 14 indicated there had been a large frame hanging in the front entry with the Ombudsman's and other required contact information at one time but it had broken. The Ombudsman information had then been placed in a 8.5 inch (in) x (by) 11.0 in plastic photo picture frame that sat on the receptionist desk. She did not know where the frame had gone, and she would speak to the Administrator (ADM). During an interview on 4/25/24 at 1:00 p.m., the ADM indicated the Ombudsman information had been posted near the front entry of the Skilled Nursing Facility (SNF) health center, someone had stolen their signs. Upon looking, she had found the Ombudsman information had also been taken from the licensed residential building. This information was supposed to have been posted and she would be making new signs. On 4/25/24 at 1:25 p.m., Receptionist 14 was observed to leave the conference room with a large frame that had been turned backwards and leaned against the wall. She indicated it was the frame that had been broken that contained contact information for the Ombudsman. On 4/29/24 at 3:40 p.m., the ADM indicated the facility had no specific policy regarding the posting of Ombudsman information. (continued on next page)

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	3.1-4(j)(3)(C)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 38767 Based on observation, interview, and record review, the facility failed to address resident grievances regarding missing clothing and hearing aids (Residents C, J, and Q). Findings include: Confidential interviews were conducted during the survey: a. Patient laundry was frequently missing and there had been multiple complaints by family members looking for their loved one's clothes. b. Concerns about resident care and the quality of resident care were reported to the nursing staff multiple times, and the receptionist. There was no response from management regarding the concerns. Grievance logs, dated January - April, 2024, indicated 2 resident requests to return to Assisted Living, and 1 concern from resident council regarding dietary issues, menu food items, and a resident request for peanut butter and jelly. 1. During an interview on 4/23/24 at 12:44 p.m., a family member indicated after Resident C was admitted the family noticed the resident's clothing was missing. Upon questioning the staff multiple times, they just kept saying they knew nothing about her clothes. Resident C's record was reviewed on 4/24/24 at 9:55 a.m. The record lacked documentation of clothing or missing clothing. Grievance logs, dated 2024, indicated there were no documented concerns regarding missing clothing. During an interview on 4/26/24 at 9:45 a.m., the Administrator (ADM) indicated Resident C's record lacked documentation of an Inventory of Personal Effects being completed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 4/24/24 at 2:40 p.m., a family member indicated, Resident J's admitted to the health center a few months ago with 4 complete sweat outfits to include matching top and bottoms, nightgowns, underclothing and socks. As of this time all of Resident J's clothing had been lost except for the light blue sweat outfit she was wearing and 1 nightgown. The family member indicated Resident J's representative had reported resident's hearing aids and clothing missing multiple times. Nothing had been found or an offer made for the items to be replaced by the facility. This was not the first time an item belonging to Resident J had been lost by the facility. It just kept happening repeatedly. They had not been aware they could file a concern with staff to help track the missing items. The family member indicated when she came to visit on this date that she had brought 4 light weight shirts of her own in for the resident to wear until her clothing could be found or replaced. The resident's television (TV) had the volume turned up to 98 due to the resident's missing hearing aides. The Social Services Director (SSD) indicated she would look for the items, but the family had not heard back from her. On 4/25/24 at 11:46 a.m., Resident J was observed standing in the bathroom wearing only a light blue sweatshirt from the day prior. 3 lightweight shirts were observed hanging in the closet, there were no pants observed in the room. During an interview on 4/25/24 at 11:52 a.m., Certified Nursing Assistant (CNA) 9 indicated she routinely worked on the hallway with Resident J. The resident had been admitted to the skilled nursing facility (SNF) a few months ago from assisted living. When the resident moved into the present room in the past week, she had only the 1 sweat outfit she was wearing and a gown. CNA 9 indicated she had also heard the resident's hearing aides had been lost. CNA 9 indicated, in the past when she'd been told of a missing item by a resident or family member, she had told the nurse or the laundry. She thought there were grievance/concerns forms that could have been filled out for missing items, but she had not. She was not sure where grievance forms were located, maybe the nurse had them to fill out, but she was not sure. During an interview on 4/25/24 at 12:05 p.m., Registered Nurse (RN) 11 indicated, Resident J had moved into the secured memory care unit from assisted living. Family members would report missing items to include glasses and clothing, and a lot of the items had been found. He had heard the resident lost her hearing aids, but they never turned up. The resident liked to carry things around on the unit, and there were peers that would also mess in her things. If family members reported missing items, he would report this to the Memory Care Director, Director of Nursing (DON), laundry personnel, or sometimes the SSD. He had never been informed to use a grievance form to report missing items or for concerns. On 4/25/24 at 2:36 p.m., Resident J was observed sitting by herself in a wheelchair (wc) in front of the nurse's desk. The resident was wearing the same light blue sweatshirt as the 2 prior days, slate blue sweatpants, no socks, and mismatched house slippers on her feet. Grievance logs, dated 2024, indicated there was no documentation regarding missing clothing or hearing aids. During an interview on 4/26/24 at 9:45 a.m., ED indicated the resident record lacked an Inventory of Personal Effects list had been completed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/26/24 at 10:24 a.m., the SSD indicated, she was aware of family current concerns of the missing clothing, hearing aid, and a white blanket. There had not been grievance forms filled out, and the items had not been found. During an interview on 4/26/24 at 4:30 p.m., the SSD indicated, some of resident's clothing and her blanket had been found. She had no answer as to why the items had been missing for weeks after being reported by family, but found on this date. 3. During an interview on 4/25/24 at 10:40 a.m., Resident Q's family member indicated the resident was missing a lot of clothing which he had reported to laundry and nursing staff. She no longer had any bras, her socks were missing, and most slacks including a pair of blue velvet sweatpants he had just reported a few weeks ago. The clothing was not being returned, and the facility had made no offer to replace any of the items. Grievance logs, dated 2024, indicated there was no documentation regarding missing clothing. On 4/26/24 at 9:45 a.m., the ADM provided an Inventory of Personal Effects, dated 10/25/19. The list included 15 pair of slacks, 23 blouses/shirts, 15 pair of socks, and 11 brassieres. The resident record lacked documentation of a more updated inventory list. During an interview on 4/25/24 at 2:39 p.m., RN 6 indicated grievance forms were located in a rack hanging on the wall inside the nurse's station and pointed to a clear rack containing 5 blank forms hanging towards the back of the nurse's station. During an interview on 4/26/24 at 10:24 a.m., the SSD indicated there had been a problem with staff not filling out grievance/complaint forms, staff were supposed to have filled out grievance forms any time there were concerns or missing items, but that had not happened. The SSD indicated she was unsure what the staff had been instructed to do regarding complaint forms, but she knew there was no current process in place where the staff filled out grievance forms, gave them to her to follow up and pass along to the ADM to review and sign, or a written response given back to complainants. Indicated, if she herself had a complaint of missing clothing she had gone straight to the laundry and looked for the clothing, she had not filled out a grievance form. If clothing had not been found, she had passed this information on to the Housekeeping/Laundry supervisor. SSD indicated, the Cans were responsible for making sure clothing were marked with resident's name when the inventory sheet was filled out upon admission to the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/24 at 3:10 p.m., the ADM provided a Grievance Program policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, The facility will post in prominent locations throughout the facility The Right to File Grievances orally [meaning spoken] or in writing: the right to file grievances anonymously .a. The contact information of the Grievance Officer .b. A reasonable expected time frame for completing the review of grievance is usually 5 days but no later than 10 days .7. Maintain a record keeping system of all complaints reported via the [Concern and Comment Program] or any other means of reporting that includes: a. Date the grievance was received. b. Summary of the resident's and/or family's grievance. c. Steps taken to investigate the grievance. d. Summary of findings and the conclusion. e. Statement of whether the grievance was confirmed or not confirmed. f. Date the written decision was issued. 8. Follow up with the resident and family to communicate the resolution and/or explanation and ensure that the issue was resolved to the resident's and/or family's satisfaction. 9. Maintain evidence that documents to result of the grievances for a period of no less than 3 years .The Executive Director [ED] and/or designee is responsible for the following: 1. Oversee the facility's overall grievance program .2. Ensure that all Grievance, Concern and Comment Reports are reviewed and addressed in a timely, appropriate manner . These Federal tags relate to Complaints IN00432486, and IN00432791. 3.1-7(2) 3.1-7(3)(b)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38767 Based on observation, interview, and record review, the facility failed to provide personalized activities to a dependent resident incapable of self-initiated activities (Resident K) and failed to consistently provide activities to a resident with dementia (Resident J) 2 of 3 residents reviewed for quality of care (Residents K and J). Findings include: During an interview on 4/24/24 at 3:31 p.m., a family member indicated the family would get upset when they visited and Resident K was out of bed every day in the morning. The family had requested the resident be out of bed in the morning and be laid down in the afternoon, therefore being up approximately 4 hours daily which would accommodate him being taken to activities. The family was also unhappy when the resident was in bed and dressed only in a T-shirt or gown and adult brief. The resident tended to be cold and family members had provided thermal tops and pajama bottoms so he would stay warm. During the last care plan meeting the family had been promised the staff would get the resident out of bed daily from around 11:00 a. m., - 3:00 p.m. daily, he loved to attend activities, like music, and to play checkers. Observations of the resident in bed not involved in activities on 4/24/24, a. At 3:23 p.m., the resident was lying on his back in the bed with eyes open, personal quilt on bed covering him up to his chin, wearing a hospital gown, the TV remote on the floor under the bed. The resident was alert, answered questions with hesitant speech, brief mostly yes or no answers. When asked how he was doing, indicated I don't know. Observations of the resident in bed not involved in activities on 4/25/24, a. At 11:03 a.m. the resident was lying on his back in the bed, wearing a hospital gown, quilt up to his chin. The resident indicated he preferred to be out of bed daily, it had been 3 days since he had been gotten up. b. At 12:52 p.m., the resident was lying on his back in the bed watching TV, wearing a hospital gown. Qualified Medication Aide (QMA) 13 indicated the resident was gotten out of bed daily when his tube feeding was done. QMA 13 indicated she could not explain why the resident had not been seen out of bed on the day shift this week. c. At 2:43 p.m., the resident was lying on his back in the bed with the quilt pulled over his head, tube feeding disconnected, the lights were off, no TV or music playing. d. At 3:39 p.m., the resident was lying in bed on his back, awake, no tube feeding hooked up, wearing a hospital gown, no TV or radio playing. Observations of the resident in bed not involved in activities on 4/26/24, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. At 12:02 p.m., the resident was lying on his back in the bed, awake, wearing a hospital gown, quilt from head to toe on right side of body, mid body and left side uncovered, the room was dark with no lights, the TV was on. Resident K indicated he had not been gotten out of bed this week, had wanted to be up. g. At 1:32 p.m., the resident was lying on his back in bed with head on a pillow, the TV was on, lights off. Certified Nursing Assistant (CNA) 22 indicated she routinely worked the resident's hallway on day shift. Staff usually got Resident K out of bed after his tube feeding had been disconnected around 1:00 p.m. as he liked to roam in his wheelchair. However, it was difficult for staff to get the resident out of bed around 1:00 p.m. as they were still serving lunch at that time. She did not know what happened this week and why the resident had not gotten out of bed. Observations of the resident in bed not involved in activities on 4/29/24, a. At 11:30 a.m., the resident was on his back in the bed. Resident K's record was reviewed on 4/26/24 at 1:39 p.m. Diagnoses on Resident K's profile included, but not limited to, hemiplegia, and hemiparesis (paralysis on one side of the body) on left non-dominant side, dysphagia (difficulty with communication to include speaking). A Quarterly/Annual Activities Participation Review, dated 11/20/23, indicated Resident K attended social events, bingo, movies, exercise, and art. The resident's favorite activities, special accomplishments, and/or new interests included bingo and social events. The resident's mother attended some programming with him also. An activity calendar dated April 22 - 29, 2024, highlighted areas indicated the resident attended 2 evening activity event on Tuesday 4/23 and Sunday 4/28 with no description of what he attended and had 2 pet visits on the evenings of 4/24 and 4/26. This did not indicate if the resident participated while in or out of bed. During an interview with the Director of Life Enrichment, she indicated an activity calendar was used to describe daily activities. The resident's attendance was documented by highlighting a census form with colored highlighters. If there was a colored mark beside the resident's name, this meant the resident had attended and dependent on the color it meant either a morning or evening event. The form did not provide documentation of what specific activity the resident attended, for what length of time, if the resident was actively involved, or was passively watching. A care plan indicated Resident K had impaired cognitive function, his family visited and family stated he likes to watch TV and sports and play cards, he could comprehend commands with yes and no jesters, he would benefit from associate support for activity participation related to interest for cognitive, social and emotional fulfillment/stimulation in group/one on one settings. The goal was for the resident to maintain involvement in activities for cognitive, emotional and social fulfillment in guided groups/one on ones. Interventions included to invite the resident to scheduled programming and provide a calendar of events and welcome by name. Provide support necessary to maximize success in programming such as cueing and assistance with crafts and games. Work in concert with family to identify supplies that can be provided to enhance their visit and activity participation within group/1:1. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS (Minimum Data Set) assessed the resident as being totally dependent with 1-2 person assistance for bed mobility, transfers, eating, toileting, and bathing. During an interview on 4/29/24 at 10:02 a.m. Nurse Practitioner (NP) 20 indicated she was in the facility 4 days per week and she had not seen Resident K out of the bed in the last week. The resident liked to be up around others and interacting. He cared a lot about his appearance, i.e. what clothing he was wearing, and he would spend a lot of time picking out a hat for any occasion. NP 20 indicated she felt the resident was most comfortable when he was up out of bed. He was a proud veteran and liked when others acknowledged it, he liked to flirt, and be told he was [NAME]. During an interview on 4/29/24 at 11:29 a.m., the Director of Life Enrichment indicated she put out the activity calendar monthly, calendars were no longer put on the walls in resident rooms since walls had been painted, but cognitive residents were given a calendar by hand. Staff tried to remind residents of the day before and day of activities, then would go around and ask those who were up if they wanted to attend. Lower functioning residents usually attended morning activity, but if not up they would be invited to an afternoon activity. Bed ridden residents would have in-room one on one (1:1) activities twice weekly. Staff kept track of resident participation by marking on a calendar if attended, and 1:1 documentated was kept in a book. Resident K usually attended afternoon activities, he liked pet visits and daily chronicles. When his mother visited, she made sure he went down to activities. The resident had to be separate from his peers if the activity involved food as he could eat nothing per mouth and would try to take food from others. The Director of Life Enrichment indicated Resident K had a lot of room stimulation with TV and reading the daily chronicle. She had not seen him down in activities the last week as his mother had not been in, but he had pet visits twice last week on Wednesday and Friday when in bed and watched the TV. 2. During an interview on 4/24/24 at 2:40 p.m., a family member indicated Resident J had moved from the assisted living building a few months ago into the secured memory care unit, but that area was too busy with all the residents and staff distraction around her, so as of a week ago she was residing in the health center in a room by herself. The resident's dementia was progressing, she was more confused, had new behaviors of being paranoid, and did not like to be around crowds of other people. The resident was observed rambling talk non-stop, nothing to do with the conversation, but talking to and smiling at her family member. The family member indicated to make herself heard she had to be close to the resident and yell in her ear. When the family member came to visit this date, the TV volume was set to 98, very loud, to accommodate the resident hearing due to having her hearing aids lost. To her knowledge, there had been no suggestions from staff for the resident to try headphones or a portable hearing box to better hear the TV. On 4/24/24 at 3:05 p.m., Resident J was observed walking out of her a room with a visitor who was leaving. The resident ambulated with a slightly stooped posture with halting steps, ambulated only a few steps into the hallway then turned around and went back into her room. On 4/25/24 at 11:27 a.m., Resident J was observed sitting in a straight chair in the room dressed only in her night gown pulled up above her waist, attempting to put on a bra. On 4/25/24 at 11:52 a.m., Certified Nursing Assistant (CNA) 9 indicated she routinely worked on the hallway with Resident J. The resident had been admitted to this room in the past week, the resident was hard of hearing, the aide heard the resident's hearing aids had been lost. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 12:05 p.m. Registered Nurse (RN) 11 indicated, Resident J had moved into the secured memory care unit from assisted living for more care, but moved out when the atmosphere was too busy for her. He had heard the resident lost her hearing aids, but they never turned up. On 4/25/24 at 2:36 p.m., the resident was observed sitting by herself in a wheelchair (wc) in front of the nurse's desk, feet propped on the wc pedals, hair down around her face, right elbow on the wc arm allowing her face to be propped on her hand. Several staff and fell ow residents were observed sitting by or walking up and down the hallway in front of the resident, the staff were conversing, and the phone on the desk within 6 feet of the resident was ringing. The resident was dressed in a light blue sweatshirt and slate blue sweatpants, no socks, and mismatched house slippers on her feet. Resident J's record was reviewed on 4/29/24 at 3:55 p.m. Diagnoses on Resident J's profile included, but not limited to, Alzheimer's disease, cancer of the pancreas, and major depressive disorder. A Quarterly/Annual Activities Participation Review, dated 11/20/23, indicated the resident attended social events, bingo, movies, exercise and art. The residents' favorite activities, special accomplishments, and/or new interests, were bingo and social events. For the past week the highlighted areas indicated the resident had pet visits on 4/19, 4/24, and 4/26. There was no additional documentation the resident had attended activities. During an interview on 4/29/24 at 11:37 a.m., the Life Enrichment Director indicated Resident J had been asked to activities, but when she attended, she had to be monitored as she would wander off and had to be re-directed. So far, the most engagement was going to meals in the main dining room as this resident liked to drink coffee. Resident J was higher functioning, so she was invited out of her room. The facility tried not to have as many residents on one on one (1:1), so Resident J was still part of the group activities. The resident was hard of hearing, and liked to watch TV. The facility had no headphones or hearing devices to offer the resident for when the resident was in a group activity. Resident J had just moved over from the memory care unit where they only had group activities and the activities were not tracked, but now that she was in the health care center her activity participation should have been tracked. An Admission and State Optional MDS's (Minimum Data Set) were completed on 2/20/24, the resident was assessed as having adequate hearing, had hearing aids, could sometimes make herself understood, and sometimes understand others. The resident was unable to participate in a BIMS (Brief Interview for Mental Status) assessment. The resident displayed no signs or symptoms of wandering. Mobility devices included a walker. The resident required extensive assistance with one person physical assist for bed mobility, supervision of one person physical assist for transfers, and supervision and set up help only for toilet use. The resident was not involved in completing documentation for daily and activity preferences. Staff and family involvement in care discussions indicated this resident enjoyed listening to music, being around animals such as pets, and doing things with groups of people. The resident's record lacked documentation of care plans for activity preferences or personal preferences for care. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the SSD on 4/26/24 at 10:24 a.m., she indicated the resident's hearing aides were missing, to her knowledge no one had offered the resident headphones, a pocket hearing devices, or any other intervention so she could listen to the TV without her having to be directly in front of the TV or having the volume high enough to disturb the neighbors. 3.1-33(b)(5) 3.1-33(d)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38767 Based on observation, interview, and record review, the facility failed to ensure fall follow up was completed to include neurological (neuro) checks, 72 hour follow up documentation, interventions were initiated, and care plans were updated, for 2 of 2 residents reviewed for falls (Residents C, and K). Findings include: Confidential interview was conducted during the survey, indicated falls and minor injuries were not always being reported and monitored especially on residents who fell frequently or were confused. 1. During an interview on 4/23/24 at 12:44 p.m., Resident C's family member indicated the resident had several falls in the facility due to being so weak. The family received a call from the physician stating the resident was in the hospital after passing out on the toilet, but when the facility was called for follow up questions, the family was told the resident passed out in the main dining room. Resident C's record was reviewed on 4/24/24 at 9:55 a.m. Diagnoses on Resident C's profile included, but not limited to, muscle weakness, difficulty walking, and lack of coordination. A Fall Risk Data Collection assessment was completed on 2/5/24, a score of 22 indicated high risk for falls. The resident had 1-2 falls in the past 90 days, her cognitive status had changed in the last 90 days, elimination with assistance, and she was confined to a chair. A clinical admission notes, dated 2/5/24 at 8:27 p.m., resident arrived at the facility via ambulance. The resident was able to move all her extremities, although there was no improvement in range of motion. Her gait was unsteady, balance poor, and she was bedfast all or most of the time. A progress notes, dated 2/8/24 at 10:37 a.m., physical therapy (PT) reported to nursing staff that the resident was eligible for sit-to-stand transfers. A brief interview for mental status (BIMS) assessment, dated 2/10/24 at 11:33 p.m., a score 3/15 indicated severe cognitive impairment. A progress notes, dated 3/9/24 at 10:32 p.m., the patient scooted herself off the low bed onto the floor and refused to get back into bed stating she was fine. A progress notes, dated 3/13/24 at 12:36 p.m., the resident was found on the floor. The resident stated she had tried walking to the door and her wheelchair (wc) was locked and she fell trying to ambulate. The resident was put back into bed and therapy was in the room with the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident record lacked documentation root causes had been determined for the 3/9/24 and 3/13/24 incidents of the resident being on the floor. There were no fall follow ups times 72 hours, no documentation the physician or resident representative were notified, no post fall or pain assessments completed, no immediate intervention put into place, or care plan added. A progress notes, dated 4/11/24 at 10:14 p.m., the resident was using the toilet when she lost consciousness, 911 was called and the resident left for evaluation at the emergency room (ER). An Incident by incident tracking type report, dated 2024, indicated Resident C was not on the tracking log as having fallen during her admission. The Admission and State Optional MDS's (Minimum Data Set) assessments, completed on 2/12/24, assessed the resident as having the ability to make herself understood and to understand others. A BIMS (brief interview for mental status) score 3/15 indicated severe cognitive impairment. The resident required extensive assistance of one person physical assist for bed mobility, transfers, and toilet use. The resident had no falls in the month prior to admission or 2- 6 months prior to admission. A care plan, dated 2/5/24, indicated the resident had documented safety concerns. The goal was for the resident to remain safe. Interventions included encouraging use of prescribed assistive devices and performing safety risk evaluation(s) on admission, as needed and upon changes in condition. Safety measures - including strategies to reduce the risk of infection, falls, injury initiated as appropriate. On 2/26/24 the resident put herself on the floor and went back to bed. During an interview on 4/29/24 at 9:49 a.m., Nurse Practitioner (NP) 20 indicated the resident was admitted back to the hospital after having a syncope (passed out) episode in the bathroom and had not returned to the facility as of this time. 2. Resident K's record was reviewed on 4/26/24 at 1:39 p.m. Diagnoses on Resident K's profile included, but not limited to, hemiplegia, and hemiparesis (paralysis on one side of the body) on left non-dominant side, dysphagia (difficulty with communication to include speaking). On 4/24/24 at 3:23 p.m., Resident K was observed lying on his back in the bed with his eyes open, head of the bed (HOB) less than 30 degrees, personal quilt covering him up to his chin, television (TV) remote on the floor under the bed, fall mat on floor on left side of the bed. The resident was alert, answered questions with hesitant speech and brief mostly yes or no answers. When asked how he was doing, indicated I don't know. A Fall Risk Data Collection assessment, dated 12/28/23, score of 16 indicated the resident was at high risk for falls. If resident was at risk for falls (total score is 10 or more) select the appropriate care plan items below. No fall care plan found. A progress notes, dated 3/1/24 at 7:12 a.m., indicated the resident had a witnessed fall today at 6:00 a.m., no injuries sustained. Voicemail messages were left for the physician and power of attorney (POA). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Post Fall Evaluation, created by Licensed Practical Nurse (LPN) 21 on 3/2/24 at 3:52 a.m., effective date 3/1/24 at 6:37 a.m., indicated the resident had a fall witnessed by a night aide, the resident was incontinent and soiled. Fall Risk score of 18 indicated high risk for falls. There were no injuries noted. The resident record lacked documentation 72 hour fall follow up assessments were documented, the family was notified of the fall, and there was no fall care plan. During an interview on 4/24/24 at 1:47 p.m., Registered Nurse (RN) 6 indicated, if a resident fall was reported as witnessed, the nurse should have assessed the resident head to toe for injury to include vital signs, and if no injury document the incident in the electronic medical record (EMR), then call the Director of Nursing (DON), physician, and resident's family. The fall would be followed up and documented in the nurse's notes for 3 days. If the resident had an unwitnessed fall, the nurse would complete the same fall follow up process, assessment, and EMR documentation, but also complete neuro checks which were documented on paper. The management team was responsible for creating and updating the resident's care plan. On 4/29/24 at 5:30 p.m., the Administrator (ADM) indicated the resident was not usually given is bed remote as he would push the button until in high position and was at risk for falls. On 4/29/24 at 3:10 p.m., the ADM provided a Fall and Fall Risk, Managing policy, dated March 2018, and indicated the policy was the one currently being used by the facility. The policy indicated, 1. The staff, with input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor[s] of falls for each resident at risk or with a history of falls .5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . This Federal tag relates to Complaint IN00432791 and IN00433009. 3.1-45(a)(1) 3.1-45(a)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 38767 Based on observation, interview, and record review, the facility failed to properly elevate the head of the bed for a resident receiving nutrients via a gastroscopy tube (g-tube) with a known history of aspiration pneumonia (when food or liquid is breathed into the airways or lungs instead of being swallowed), and put a label on infusing bags of tube feeding formula for 1 of 1 resident observed for tube feeding (Resident K). Findings include: During a random observation on 4/24/24 at 3:23 p.m., Resident K was observed lying on his back in the bed with eyes open, and tube feed formula infusing per pump at 70 ml/hr (milliliters per hour). Neither the bag of formula or bag of water hanging next to the formula had a label to indicate the date or time the formula was hung, name of the nurse who hung the formula, or name and physician's order for the formula, or physician's order for the water. During an interview on 4/24/24 at 3:31 p.m., a family member indicated, the family had gotten upset when they visited and Resident K was lying flat in bed without the HOB elevated, it was dangerous and could causes him to have another episode of aspiration pneumonia. Indicated, everyone knew that a resident was required to have the HOB elevated at least 30 - 45 degrees when the tube feed formula was infusing or within a few hours after it had been disconnected. The family member indicated she had voiced her concerns to the facility management, but nothing had been resolved. On 4/25/24 at 11:03 a.m., the resident was observed lying on his back in the bed, HOB less than 30 degrees, feeding tube formula infusing at 70 ml/hr. The formula bag had 4/24 written in marker on the bag, there was no label on the formula bag or water bags. On 4/25/24 at 12:52 p.m., the resident was observed to be lying on his back in bed watching television (TV), his feeding tube and water had been disconnected. On 4/25/24 at 2:43 p.m., the resident was observed lying on his back in the bed with the quilt pulled over his head, tube feeding disconnected. On 4/25/24 at 3:39 p.m., the resident was observed lying in the bed on his back, awake, the tube feeding disconnected, HOB less than 30 degrees. On 4/26/24 at 12:02 p.m., the resident was observed lying in bed on his back, tube feeding infusing per pump at 70 ml/hr, HOB elevated less than 30 degrees. On 4/26/24 at 1:32 p.m., the resident was observed lying on his back in bed with his head on a pillow, HOB less than 30 degrees. On 4/29/24 at 11:30 a.m., the resident was observed laying on his back in the bed, pillow under his head, HOB elevated less than 30 degrees, unidentified nurse observed at beside looking at the feeding tube pump and bags of formula and water. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident K's record was reviewed on 4/26/24 at 1:39 p.m. Diagnoses on Resident K's profile included but were not limited to, history of pneumonitis due to inhalation of food and vomit, hemiplegia, and hemiparesis (paralysis of one side of the body) of left non-dominant side, dysphagia (difficulty swallowing), and gastro-esophageal reflux disorder (GERD - occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Physician's orders indicated, a. On 3/30/24 change g-tube enteral feeding bag and tubing every 24 hours. b. On 3/27/24 Osmolite 1.5 Cal liquid, give 70 ml/hr via g-tube one time a day, 45 ml auto flush every 4 hours up at 6:00 p.m., off at 2:00 p.m., and remove per schedule. c. On 3/27/24 turn every 2 hrs while in bed every shift for skin care. d. On 3/27/24 elevate HOB 30-45 degrees during feeding and at least one hour post feeding every shift. A progress note, dated 4/22/24 at 11:08 p.m., indicated the resident was alert and able to make simple desires with jesters. G-tube patent and infusing at 60 cc/hr via pump with water (H2O) flush. A progress note, dated 4/24/24 at 11:49 p.m., indicated the resident was alert and able to make needs known. G-tube intact with dry dressing, and patent with pump infusing at 60 ml/hr with H2O flush. A care plan indicated Resident K required tube feeding related to dysphagia, and swallowing problems. The goal was for the resident to maintain adequate nutrition and hydration. Interventions included, the resident needed the HOB elevated 45 degrees during and thirty minutes after tube feed. On 3:10 p.m., the Administrator (ADM) provided a Enteral Feedings - Safety Precautions policy, dated November 2018, and indicated the policy was the one currently being used by the facility. The policy indicated, Preventing errors in administration: 1. Check the enteral nutrition label against the order before administering. Check the following information: a. Resident name, ID and room number, b. Type of formula, c. Date and time formula was prepared, d. route of delivery, e. access site, f. method [pump, gravity, syringe], Rate of administration [ml/hr]. 2. On the formula label document initials, date and time the formula was hung, and initial that the label was checked against the order. Preventing aspiration .3. Elevate the head of the bed [HOB] at least 30 degrees during tube feeding and at least 1 hour after feeding . This Federal tag relates to Complaint IN00433009. 3.1-44(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robin Run Health Center	6370 Robin Run W Indianapolis, IN 46268

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38767 Based on observation, and interview, the facility failed to ensure dietary staff covered facial hair during food preparation, maintained clean and sanitary conditions in the kitchen, pantry, and pantry refrigerator, and food was stored at proper temperature for 3 of 3 food storage and food preparation areas observations. This deficient practice had the potential to affect 79 residents who received food from the kitchen. Findings include: A grievance documented from the resident council, dated 3/28/24, indicated dietary issues, and menu food options. A resident requested for dietary to provide peanut butter and jelly. During a random observation of the satellite kitchen, on 4/29/24 at 9:15 a.m., the satellite kitchen manager indicated food was usually kept approximately 30 minutes after meals for residents who requested leftovers. Indicated the satellite kitchen was locked after dietary staff left for the evening, so pitchers of juice and peanut butter sandwiches were left in the pantry on the nursing unit to be used for evening snacks, nursing staff had no access to ice cream cups, pudding, lunch meat, or the juice machine after hours. The satellite kitchen manager indicated there was no resident specific snack list available to direct the dietary staff to provide snacks per resident preferences or diabetic replacements. On 4/29/24 at 9:25 a.m., observation of the main kitchen with the satellite kitchen manager. Two unidentified kitchen staff were observed prepping raw chicken breasts, both male staff members had full beards more than 1 inch in length, neither were wearing a beard cover. The floors of the kitchen, underneath and on the sides of the stoves, ovens, and deep fryers, were observed to have a build up of grease and debris including trash, and food. She indicated this kitchen provided food to all residents and staff who ate on campus. On 4/29/24 at 9:28 a.m., observation of the kitchen with the executive chef, who indicated she had not worked over the weekend, but each kitchen staff member was responsible for cleaning their own stations. Confidential interviews were conducted during the survey: a. The pantry on the unit was frequently filthy and smelled. b. In the evening once the meal trays were passed, the kitchen staff immediately threw away any extra food, so if the residents wanted more to eat, they did not have that option. c. Snacks were not consistently being offered or provided outside of mealtimes, especially diabetic residents' bedtime snacks. d. Nursing staff did not have access to juice off hours in the event of a diabetic emergency. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/34 at 9:32 a.m., observation of the panty by the nurse's station with Certified Nursing Assistant (CNA) 18. Trash and food debris was observed on the floor and under the ice machine. The refrigerator had a sign taped on the front of the freezer indicated for resident use only. The inside of the refrigerator had 4 bags of food or styrofoam containers with resident names written on them, 3 large bottles of juice and cartons of supplements in the door, and the thermometer read 54 degrees Fahrenheit (F). There was unidentified food debris on the shelves, and red and yellow dried liquid substances dripped on the bottom drawer and down the inside of the door. CNA 18 indicated the unlabeled food items belonged to the staff, and she was not sure who was responsible for cleaning the pantry or the refrigerator. On 4/29/24 at 9:38 a.m., an opened gallon container of milk observed to be half full, undated, and with no lid was observed on the 2nd shelf of a utility cart with 2 coffee dispensers, and sugar packets on the top shelf positioned in the hallway across the hallway outside the pantry door. When asked how long the milk had been sitting out opened, CNA 18 indicated the milk was served to residents during the breakfast meal. During an interview on 4/29/24 at 10:39 a.m., the Director of Dietary indicated the dietary department used to leave snacks on the nursing floor to include turkey sandwiches. But a few months back there had been theft issues from the satellite kitchen, so dietary staff started locking it, and now snacks and juices were left in the pantry. Food in the satellite kitchen was kept 30-40 minutes in the steam wells after each meal in case a resident ate late or asked for seconds. The Director of Dietary indicated there was an on-going problem of nursing staff putting their food in the resident refrigerator in the pantry despite a recent meeting about the problem. Dietary staff was responsible for keeping the resident refrigerator in the panty cleaned out. The nursing staff should have put milk on ice if leaving it out for an extended time during breakfast services. Beard covers should have been worn by staff with beards working on food preparation or serving. Observation of the pantry refrigerator indicated there were no resident snacks i.e. sandwiches or pudding observed in the refrigerator, and the thermometer read 54 F. The satellite kitchen manager told him the pantry refrigerator was documented by kitchen staff as having been cleaned out daily. On 4/29/24 at 10:56 a.m., observation of the panty refrigerator being replaced. Maintenance staff 4, indicated the refrigerator was not holding its temperature due to the broken rubber seal that was observed hanging down from the bottom of the door. The DON indicated nursing staff food was not to be stored in the resident's refrigerator. On 4/29/24 at 11:20 a.m., observation of the pantry refrigerator with the Administrator (ADM), the 4 food trays marked with resident names were observed to have been placed back into the replacement refrigerator. The ADM indicated staff members were not supposed to store their personal food among the resident food, and the resident food should have been thrown away related to the prior refrigerator not being cool enough. A Refrigerator Temperature Log, dated April 2024, indicated, each evening shift, please check the temperature of the refrigerator and record it. The normal temperature range should be between 35 - 45 F. If the temperature is different, please notify the ADM. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/24 at 10:55 a.m., the ADM provided a Sanitization policy, dated October 2008, and indicate the policy was the one currently being used by the facility. The policy indicated, The food service area shall be maintained in a clean and sanitary manner .1. All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish .2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair . On 4/29/24 at 10:55 a.m., the ADM provided a Food Preparation and Service policy, dated April 2019, and indicate the policy was the one currently being used by the facility. The policy indicated, Food and nutrition services staff wear hair restraints [hair net, hat, beard restraint, etc.] so that hair does not contact food . No policy regarding resident snacks was obtained during the survey process. This Federal tag relates to Complaints IN00432486, and IN00433009. 3.1-21(e) 3.1-21(i)(3)