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	12/20/2024

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

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46414 Based on interview and record review, the facility failed to manage pain for a resident with a history of falls, who was experiencing pain related to a fall with a fracture of her left hip for 1 of 4 residents reviewed for falls (Resident B). Findings include: A record review was conducted on 12/20/24 at 2:10 p.m. Resident B had the following diagnoses which included, but not limited to, osteoarthritis of the knee, malignant neoplasm of head of pancreas (pancreatic cancer), adult failure to thrive, Alzheimer's disease (degenerative brain disorder), major depressive disorder, and insomnia. Resident B had a care plan, dated 2/25/24, which indicated she was at risk for falls related to confusion, diagnosis of dementia (degenerative brain disorder), left femur (thigh bone) fracture with impaired safety awareness, unsteady gait (walk) at times, diagnosis of pancreatic cancer, and possible side effects from medications. Resident B's illness has progressed, and she had become weaker and needed more assistance. She continued to attempt to self-ambulate due to impaired safety awareness. Her goal was to not sustain serious injury. Interventions included to take her to the toilet at 6:00 a.m., and to offer early morning get up between 5:00 a.m. and 6:00 a.m. A nursing progress note, dated 12/20/24 at 6:09 a.m., indicated Resident B had a fall at 5:05 a.m., while the resident was attempting to self-toilet. She was found with a bruise and cut to her head. She was wearing oxygen at the time of the fall and her oxygen saturation was 98%. The note did not mention any pain in the initial note. Resident B had orders for tramadol (used to treat pain) 50 mg (milligram) scheduled routinely for 9:00 a.m. and acetaminophen 500 mg, take 2 tablets routinely at 9:00 a.m. A nursing progress note, dated 12/19/24 at 10:13 a.m., indicated the Nurse Practitioner (NP) 8 was at the facility to see Resident B's laceration (open cut) to her head and her complaint of pain in the left hip. The left leg was noted to be shorter than the right leg. Resident B's daughter was there and waiting for a hospice nurse to arrive. An order from the NP 8, dated 12/19/24, around 10:30 a.m., indicated to obtain x-ray with 2 views of the left hip related to the fall and increased pain. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 12/19/24 at 12:29 p.m., indicated the hospice nurse was present and the results of the x-ray showed a fracture of the femur. NP 8 was notified, and family was present with Resident B. An order from the hospice nurse, dated 12/19/24 at 12:41 p.m., indicated to administer lorazepam (an antianxiety medication) 2 mg/ml, (milligram/milliliter) to give 0.5 ml every 6 hours as needed, Norco (a pain killer) 5/325mg, give 1 tablet every 4 hours as needed, and Macrobid (an antibiotic) 100 mg, give 1 capsule two times daily for 7 days. A nursing progress note, dated 12/19/24 at 2:18 p.m., indicated the family made the decision to have her transported to a local hospital for evaluation and treatment. She was transported by stretcher. Neurological assessments were initiated. They were performed on 12/19/24 at 6:03 a.m., 6:31 a.m., 6:45 a.m. , 7:00 a.m., 7:30 a.m., 8:00 a.m., 12:51 p.m. and 12:57 p.m. Vital signs were completed two times at 5:48 a. m. and 6:17 a.m. During a confidential interview, an indication was made that Resident B was in obvious pain. Resident B was crying out and wincing and had a laceration on the back of her head with blood on her pillow. An unidentified facility nurse and NP 8 got someone to clean it up the blood. During an interview with Licensed Practical Nurse (LPN) 5 on 12/20/24 at 1:40 p.m., she indicated she got to work at 7:30 a.m. She went to assess Resident B and requested NP 8 to see her. She was only administered her routine tramadol and acetaminophen at 8:30 a.m. LPN 5 knew the resident was in pain and was quite taken aback. LPN 5 showed the x-ray which indicated an obvious break. Resident B did not know how to use a call button and sometimes her nasal oxygen cannula was on the floor. During an interview with RN 7, on 12/20/24 at 1:49 p.m., she indicated she was the nurse on duty when Resident B fell . She went in to administer Resident B's levothyroxine (used to treat hypothyroidism) and found her laying on the floor. She indicated that when she touched Resident B's leg, she would shout out. She treated her head wound with saline and wrapped her head with a gauze bandage to keep the dressing secure. She called hospice and they told her they would send a nurse right away. Resident B was unable to rate her pain. The nurse indicated her pain was around a 4 based on a scale of 0-10 according to her symptoms. RN 7 indicated she did not request or administer any pain medication since she was told hospice was on their way. During a confidential interview, on 12/20/24 at 2:00 p.m., it was indicated Resident B would have surgery 12/21/24 due to a low hemoglobin. It was so low the hospital had to administer her 2 units of blood. They wanted to get her cardiac status stable. During an interview with LPN 5, on 12/20/24 at 2:06 p.m., she indicated the hospice nurse did not arrive until around 12:30 p.m. The resident's family was present. The family was unsure if they wanted to treat the fracture or not. They decided to treat her pain and leave her there and then they changed their minds and wanted to treat her fracture with an orthopedic consultation. The hospice nurse had left the facility unaware of the family's decision to discontinue hospice and sent her to the hospital. NP 8 ordered the x-ray at 10:30 a. m. and ordered a treatment for the laceration to resident's head. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/24 at 3:02 p.m., the Executive Director (ED) indicated she was not aware the hospice nurse gave an order for Resident B to receive any pain medications. On 12/20/24 at 3:24 p.m., the ED indicated when the nurses assessed and when the resident was in pain, pain medications should be given. A policy titled, Falls Management Programming Healthcare, dated 11/14/23, was provided by the ED, on 12/20/24 at 2:56 p.m. It indicated, .perform neuro-checks according to organizational party and to immediately notify the attending physician and family of condition changes A policy titled, Administering Pain Medications, dated March 2020, was provided by the ED, on 12/20/24 at 3:25 p.m. It indicated, .Pain management is defined as the process of alleviating the resident's pain based on his or her clinical assessment and established treatment goals and the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management This citation relates to Complaint IN00449634. 3.1-37(a)