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	08/18/2025

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on interview, and record review, the facility failed to maintain a system for management of resident funds, and return personal funds within 30 days of discharge, for 8 of 11 residents reviewed for misappropriation of property (Residents F, G, H, J, K, L, M, and N). Findings include:Anonymous concerns during the survey process indicated that residents' personal money was being mismanaged by management. Residents had not been reimbursed 30 days after discharge, and some non-return of funds dated back to residents who discharged in December 2023. Eleven (11) resident accounts were reviewed for reimbursement. a. On 4/16/25, Resident F's account was closed, and a refund of $2940.97 was still due. b. On 6/22/23, Resident G's account was closed, and a refund of $839.00 was still due. c. On 4/16/24, Resident H's account was closed, and a refund of $73.40 was still due. d. On 9/24/24, Resident J was discharged from the facility, and a refund of $100.00 was still due. e. On 11/12/24, Resident K's account was closed, and a refund of $16.18 was still due. f. On 5/28/24, Resident L's account was closed, and a refund of $160.00 was still due. g. On 11/12/24, Resident M's account was closed, and a refund of $7480.00 was still due. h. On 5/14/24, Resident N's account was closed, and a refund of $2121.48 was still due. During an interview on 8/14/25 at 12:02 p.m., the Business Office Manager (BOM) indicated resident money was managed by a third-party money management system from the corporate office. Resident/resident representatives were provided with a monthly statement that explained money received and spent on behalf of the resident, and the monthly balance. The BOM input resident census status daily into an electronic report, which could be reviewed by the corporate office daily. After a resident discharged from the facility for any reason, the resident bill was settled at the facility, and in approximately 30 days the BOM submitted a request to the accounts payable program, with the expectation that a check/refund would issue from the corporate office. On 8/18/25 at 3:45 p.m., the BOM provided a Conveyance of Resident Funds policy, dated March 2021, and indicated the policy was the one currently being used by the facility. The policy indicated, The resident's personal funds and a final accounting of funds are returned to the resident, the resident's representative or to the resident's estate [individual or probate jurisdiction per state law], as applicable, withing thirty [30] days from the date of the resident's discharge or eviction from the facility, or death.This citation relates to Intake 2583293, and 2590546. 3.1-6(h)

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure residents who were dependent on staff for bathing and showering assistance received those services for 4 of 15 residents reviewed for Activities of Daily Living (ADL) assistance (Residents C, P, Q, and R). Findings include:A confidential concern during the survey indicated there were residents that had not received a showerer for over a month.1. On 8/15/25 at 12:45 p.m., Resident C was observed sitting in a manual wheelchair (WC) at bedside with his feet propped on a bed, his hair was combed but looked greasy. The resident indicated that he had only received 1 shower since his admission to the facility a few weeks prior. An aide had been assisting him to bed one evening and offered to help him with a shower, and at the time he was pleased as his hair was gummy and slimy, and he had a doctor's appointment the next day and wanted to look presentable. Point of Care (POC - an electronic documentation system) documentation indicated, Resident C was scheduled to have a shower weekly on Tuesday and Friday. Documentation of bathing in the past 30 days included a shower on 8/12/25. There was no documentation of the resident having refused to have a shower. Resident C's clinical record had no care plan related to refusals of care, or resident preference for bathing/showering. 2. On 8/15/25 at 1:25 p.m., Resident P was observed lying in bed with her eyes closed. There was a strong urine odor in the room that permeated out into the hallway. POC documentation indicated, Resident P was scheduled to have a shower weekly on Monday and Thursday. Documentation of bathing in the past 30 days included a shower on 7/17/25. There was no documentation of the resident having refused to have a shower.Resident P's clinical record had no care plan related to refusals of care, or resident preference for bathing/showering.3. On 8/15/25 at 1:25 p.m., Resident Q was observed lying awake on his bed watching TV. There was a strong urine odor in the resident's room that permeated out into the hallway. POC documentation indicated, Resident Q was scheduled to have a shower weekly on Tuesday and Friday. Documentation of bathing in the past 30 days indicated the resident had not received a shower. There was no documentation of the resident having refused to have a shower. Resident Q's clinical record had no care plan related to refusals of care, or resident preference for bathing/showering.4. On 8/15/25 at 1:25 p.m., Resident R was observed lying on her bed among a large number of personal items, she had a disheveled appearance. POC documentation indicated, Resident R was scheduled to have a shower weekly on Wednesday and Saturday. Documentation of bathing in the past 30 days indicated the resident had received showers on 7/1925, and 8/9/25. There was no documentation of the resident having refused to have a shower. Resident R's clinical record had no care plan related to refusals of care, or resident preference for bathing/showering.On 8/18/25 at 11:07 a.m., review of handwritten shower/skin sheet documentation with the Medical Records Supervisor, dated July and August 2025. There was no further documentation of showers having been given for Residents C, P, Q, and R. On 8/18/25 at 3:45 p.m., the DON provided a Bath, Shower/Tub policy, dated February 2018, and indicated the policy was the one currently being used by the facility. The policy indicated, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual[s] who assisted the resident with the shower/tub bath. 3. The assessment date [e.g., any reddened areas, sores, etc., on the resident's skin] obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason[s] why and the intervention taken. 6. The signature and title of the person recording the data.Reporting: 1. Notify the supervisor if the resident refuses the shower/tub bath.This citation relates to Intake 2583293. 3.1-38(a)(2)(A)3.1(b)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure the identification, assessment, documentation, and notification of skin issues for 1 of 4 residents reviewed for wound care (Resident E). Findings include: A confidential concern during the survey indicated a resident was found to have an unexplained bruise and red area to her forehead that was never reported to the family.On 8/18/25 at 10:15 a.m., Resident E was observed sitting with her eyes closed in a lounge among peers who were watching TV. The resident was sitting in a Broda chair (a reclining geriatric care) and made a small noise, but did not move or open her eyes when the chair was moved by staff. Resident E's skin was observed to have an area of dark discoloration measuring approximately 2 (inches) by (x) 3 on the left side of her face on the temple area, extending onto the ear, and a circular area of red discoloration measuring approximate 1 1/2 on the lower forehead above the dark discoloration. Qualified Medication Aide (QMA) 14 indicated the resident rarely opened her eyes and did not transfer independently. QMA 14 indicated she had become aware of the resident having a bruise on her face on 8/6/25 but did not know the origin. Resident E's clinical record was reviewed on 8/15/25 at 3:30 p.m. Diagnoses on Resident E's profile included unspecified dementia. Annual Minimum Data Set (MDS) assessments, completed on 7/21/25, assessed Resident E as never having the ability to make herself understood or to understand others, and she could not complete the interview for mental status. The resident required extensive assistance from 1 to 2 staff for bed mobility and transfers. Resident E did not ambulate; she used a wheelchair for mobility and was propelled by the staff. On 8/7/25, a Weekly Skin Integrity Review indicated skin was not intact. Skin tear on left antecubital.A nursing progress notes, dated 8/8/25, indicated, clarification to documentation related to risk management on 7/31, fell on mat next to bed in the lowest position skin tear to left arm noted.A nursing progress note, dated 8/8/25, indicated, a bruise was found on left side of forehead, dark in color, no signs or symptoms of pain or discomfort noted, management aware, nursing will continue to monitor.On 8/8/25, facial pictures were taken of Resident E by the wound nurse. Facial bruising included an area of dark purple discoloration over the left temple extending into the hair line that measured 13.5 centimeters (cm) x 4.7 cm x 3.7 cm. There was also purplish discoloration surrounding the entire left eye.On 8/14/25, a Weekly Skin Integrity Review indicated skin was not intact. Skin tear on left antecubital.On 8/15/25, a Skin and Wound Evaluation indicated a bruise on the forehead. In-house acquired, it was unknown how long the wound had been present. The wound measured 10.2 cm x 4.7 cm x 3.0cm. On 8/15/25, a Skin and Wound Evaluation indicated redness on the right frontal. In-house acquired, unknown how long the wound had been present. The wound measured 5.4 cm x 2.9 cm x 2.5 cm. On 8/15/25, a Skin and Wound Evaluation indicated a skin tear, category 1 partial thickness, on the left outer forearm. In-house acquired, unknown how long the wound had been present. The wound measured 0.7 cm x 1.7 cm x 0.5cm. Progress resolved. On 8/15/25, a Skin and Wound Evaluation indicated a skin tear, category 1 (full thickness of epidermis and dermis are pulled in one layer from the supporting structure). Located on the left inner forearm, the wound measured 7.8 cm x 3.9 cm x 2.9 cm. There was no documentation of how long wound had been present.During an interview on 8/15/25 at 10:00 a.m., the DON indicated she had found no documentation to indicate Resident E had acquired facial bruising on 7/31/25 as a progress note had suggested. There was no documentation of bruising on the resident's forehead before 8/8/25, and no skin assessments of bruising on the forehead before 8/15/25. The DON had not found documentation of when or if the MD and family had been notified of the facial bruising. On 8/18/25 at 10:22 a.m., Licensed Practical Nurse (LPN) 13 indicated Resident E required assistance of 1 staff member for ADL's - activities of daily living, toileting and bed mobility, and she was transferred with the assistance of 2 staff members to stand and pivot. The resident did not ambulate. LPN 13 indicated, on 8/12/25 she had received report from the night shift nursing staff that Resident E had bruising on her face. The night staff did not know when the bruise had occurred. LPN 13 indicated, if she found a new skin area, she would notify LPN 12 who was the wound nurse, document a nursing progress note, and complete a skin assessment. The nurse would then notify the MD, DON, and resident representative. To her knowledge, the QMA working the evening of 8/11/25 had reported the information to LPN 8 who was the nurse in charge on the healthcare hallways, but she had no idea what the nurse did with the information. During an interview on 8/18/25 at 12:00 p.m., the DON indicated before being questioned by a visitor on 8/15/25, she had been unaware of Resident E's facial redness and bruising. The DON had initiated her own investigation at that time. The DON knew the resident had experienced a fall when she rolled out of the bed on 7/31/25 and now thought the resident might have

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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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to prevent the development of a unstageable (full-thickness skin and tissue loss wound where the depth of the injury cannot be determined because the wound bed is obscured by slough or eschar) sacral wound that resulted in wound debridement and the wound increased to a Stage 3 (Full thickness tissue loss with subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed) pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident C). Findings include:A confidential concern during the survey indicated a resident was found to have an open wound by a Certified Nursing Assistant (CNA) more than 24 hours after admission, after 3 nurses had completed skin assessments and not identified the wound.On 8/15/25 at 12:45 p.m., Resident C was observed sitting at bedside in a manual wheelchair (WC) with his feet propped on a bed, watching TV. The resident indicated he had a sore on his bottom that was a result of being left sitting on a bedpan for over 4 hours. He was unsure of the exact date the wound had been found. Resident C indicated his son had provided a WC cushion about a week ago. A wound physician had visited earlier in the week and after debriding his wound, had indicated he did not approve of the current cushion, and told the nurse to get him a different one. That had not happened. The resident indicated he was assisted by staff to get out of bed daily before breakfast and helped back into bed after dinner. Therapy personnel did not like him to lay down during the day. Resident C's clinical record was reviewed on 8/14/25 at 1:10 p.m. Diagnoses on Resident C's profile included acute kidney failure, and a pressure ulcer on the sacrum. A hospital Discharge summary, dated [DATE], indicated Resident C's skin was warm. There was no documentation of skin impairment, or orders for treatments to the skin. A Clinical admission nurse's note, dated 8/5/25, indicated documentation related to the skin had not been completed.A Clinical admission Evaluation, dated 8/5/25, indicated documentation related to the skin had not been completed. A Braden Scale for Predicting Pressure Sore Risk, dated 8/5/25, indicated Resident C was at high risk for pressure ulcers.A nursing progress notes by Registered Nurse (RN) 8, dated 8/6/25 at 9:43 p.m., indicated a wound measuring 2 centimeters (cm) by (x) 1 cm, yellowish green in color, had been found by an evening shift CNA during a brief change.Late entry Health Status nursing notes for 8/5/25 and 8/6/25, created on 8/7/25, lacked documentation related to the skin having been assessed.Late entry Skilled Evaluation nurse's notes for 8/5/25 and 8/6/25, created on 8/7/25, lacked documentation related to the skin having been assessed.A Risk Meeting notes, dated 8/7/25 at 2:00 p.m., indicated Resident C had an unstageable area on the sacrum that would be followed by wound care.A Skin & Wound Assessment, dated 8/8/25, indicated Resident C had an unstageable sacral pressure wound. The wound had slough and/or eschar and measured 3.4 centimeters (cm) x 2.4 cm x 2.1 cm. The assessment indicated the wound was present upon admission.Physician's orders, included,a. On 8/8/25, cleanse open area on sacrum with normal saline, pat dry and apply Santyl (a debriding agent), and cover with a foam dressing. Change daily and PRN (as needed).b. On 8/8/25, enhanced barrier precautions related to wounds when in close proximity for care.A Medication Administration Record (MAR), dated August 2025, indicated Santyl for wound debridement had been initiated on 8/9/25.Resident C's clinical record lacked documentation of preventative nursing interventions or use of prescribed medications from his admission date on 8/5/25 through 8/9/25. An admission MDS (Minimum Data Set) assessment was in progress, and the skin section had not been completed.A care plan, dated 8/8/25, indicated Resident C was admitted with an unstageable pressure ulcer on the sacrum or had the potential for pressure ulcer development related to immobility. Interventions included avoiding positioning the resident on his back for long periods, follow facility policy/protocols for the prevention/treatment of skin breakdown, and wound care to follow and treatment as ordered.Late entry nursing notes by RN 8, created on 8/11/25 at 10:17 p.m., included,a. On 8/7/25, area to sacrum continues to receive treatment. Drainage is present and green in color. No odor present. Resident tolerated dressing change well and no complaints of pain or discomfort.b. On 8/8/25, area to sacrum continues to receive treatment. No odor present. Resident tolerated dressing change well and no complaints of pain or discomfort. c. On 8/9/25, area to sacrum continues to receive treatment. No odor present. Resident tolerated dressing change well and no complaints of pain or discomfort. Plan of care is ongoing.Daily Skilled Evaluation notes, dated 8/5/25 - 8/12/25, lacked documentation of a sacral wound assessment.A late entry Daily Skilled Evaluation, dated 8/12/25 at 4:12 p.m., created by RN 8 on 8/12/25 at 9:21 p.m., indicated new pressure injury on the sacrum present upon admission. Measurements not documented as part of this assessment