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	12/23/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure a newly admitted resident had a code status ordered and displayed in their chart for 1 of 1 residents reviewed for code status concerns (Resident G). Findings include:On [DATE] at 11:35 a.m. Resident G's record was reviewed. They were a long-term care resident whose diagnoses included, but were not limited to, hypertension (high blood pressure) and type 2 diabetes. At the time of the review Resident G was their own responsible party. The medical record lacked an order for Resident G's code status. Hospital records, dated [DATE] at 3:15 p.m., indicated Resident G's code status for that hospital stay was a full code status. During an interview on [DATE] at 9:25 a.m. Resident G indicated they wanted to be a full code status and wished to have all interventions in place. During an interview on [DATE] at 10:57 a.m. Licensed Practical Nurse (LPN) 7 indicated she knew Resident G was a full code from the hospital records and they had the Physician Orders for Scope of Treatment (POST) (a medical document that turns a seriously ill patient's treatment wishes into portable physician's orders, covering decisions like CPR, life support, and antibiotics to ensure preferences for end-of-life care are followed) form ready for the resident's family to fill out. Resident G's family visited the Resident on [DATE]. LPN 7 indicated they knew she had visited but did not have time to have her fill the paperwork out while she was at the facility. At the time of exit a copy of a current facility policy titled, Advanced Directives, was provided. That policy indicated . The resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. Determining Existence of Advanced Directive 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or legal representative, about the existence of any written advanced directives. Decision-Making Capacity 1. Upon admission the interdisciplinary team assesses the residents decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision making capacity This citation relates to Intake 2696487. 3.1-4(d)3.1-4(e)3.1-38(f)3.1-4(l)(4)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview, the facility failed to update a resident's care plan after an allegation and incidents occurred for 3 of 5 residents reviewed for care plans (Residents B, C, and F). Findings include: 1. On 12/22/25 at 11:28 a.m., Resident B was observed sitting up in a wheelchair. She denied any pain when asked. She was noted to have bruising over the bridge of her nose, along with both eyes. She denied knowing how she received the bruising.On 12/22/25 at 1:30 p.m., observed Resident B up ambulating with her chin to her chest, making it hard to see where she was going. A record review was completed on 12/22/25 at 1:45 p.m. She had the following diagnoses to include, but not limited to, gastric reflux, anxiety disorder, hypertension, hallucinations, and Alzheimer's disease. A progress note, dated 10/11/25 at 5:12 p.m., indicated she had a history of wandering aimlessly about the unit.She had a care plan, dated 7/11/25, indicating she was at risk for wandering/elopement, she had a history of wandering into other residents' rooms and space related to diagnosis and unable to identify boundaries or safety.She had a care plan, dated 7/28/25, indicating she was at risk for falls related to confusion, dementia and refuses to wear shoes and likes to walk around bare footed. She had a care plan, dated 12/22/25, indicating she was on anticoagulant therapy.She had an order, dated 7/12/25, for aspirin 81milligrams (mg) by mouth daily for abnormal EKG (electrocardiogram).Her bruising was not updated on the care plan.2. On 12/22/25 at 1:41 p.m., Resident C was observed sitting in a wheelchair. She indicated she was at a children's party and denied any pain. She denied any allegations of sexual abuse.A record review was completed for Resident C. She had the following diagnoses which included, but were not limited to, hypertension, vitamin D deficiency, delusional disorder, osteoporosis, dementia, and schizoaffective disorder.A progress note made on 12/18/25 at 6:51 p.m., indicated Resident C made an allegation that a teacher sexually assaulted her. An investigation was initiated.On 12/22/25 at 1:51 p.m., spoke with the daughter and she indicated her mother had a urinary tract infection at the time of the allegation and she believed it was the infection that made her mother make the allegation.On 12/18/25 at 7:42 p.m., physician orders were noted by the physician for labs and to obtain urine for testing.On 12/22/25 a progress note was made indicating the urine results were reviewed by the physician and she started on an antibiotic for 5 days for a urinary tract infection.Resident C had a care plan, dated 12/2/22, indicating she had impaired cognitive functioning and impaired thought processes/encephalopathy, experiencing consistent delusions related to others trying to harm her and will ruminate on the same delusion for sometimes several days.Her care plan was not updated after the allegation of sexual abuse.3. On 12/22/25 at 1:41 p.m., observed Resident F sitting up in a chair with bruising noted to her right jawline. She denied any pain. On 12/23/25 at 10:13 a.m., a record review was completed for Resident F. She had the following diagnoses which included but were not limited to Alzheimer's disease, vascular dementia, bradycardia (slow heartbeat), and cardiomyopathy (disease of the heart muscle). On 12/15/25 a progress note indicated resident had discoloration to her jaw area after being suctioned last Friday.On 12/16/25 a progress note indicated resident had discoloration to right jaw related to being suctioned. Her record lacked a care plan for the bruising to her jawline. During an interview on 12/23/25 at 1:31 p.m., the Administrator indicated the care plans were updated after being informed the records were lacking care plans.A policy titled, Care Plans, Comprehensive Person-Centered, dated March 2023, was provided by the Administrator on 12/23/25 at 3:45 p.m. It indicated, .Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change. This citation relates to Intakes 2697032 and 2685850.3.1-35(c)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observations, interviews, and record review, the facility failed to ensure resident specific care was initiated to ensure quality of care was provided to a newly admitted resident (Resident G) for 1 of 6 residents reviewed for quality of care. B. Based on record review and interview, the facility failed to follow physician orders to monitor resident's weight daily for fluid overload and notify the physician of weight gain in 24 hours as ordered for 1 of 4 residents reviewed for quality of care (Resident D). Findings include:On 12/22/25 at 10:30 a.m. Resident G was observed yelling out from their room for help. The call light was on, and the resident was lying in bed. Resident G indicated they were desperate for someone to help them get comfortable in bed and that they had been calling for help for a while now. Resident G had on a hospital type gown, their arms were swollen, and they had very limited Range of Motion (ROM) in their arms and hands. There was a catheter bag hanging on the side of the bed that was draining urine and an oxygen concentrator set to 2 liters that was connected to a nasal cannula and was observed in Resident G's nose. Resident G's TV was playing cartoons, they indicated the TV did not work, it only had two channels, and it had been on cartoons since they had got there. Resident G indicated they didn't mind the cartoons, but it was not what they wanted to watch. Upon observing the remote, the only buttons that worked on the resident's remote were the power button and the volume buttons. On 12/22/25 at 11:00 a.m. an unknown Certified Nursing Assistant (CNA) was assisting Resident G with getting comfortable in bed, when she became frustrated with the resident. The CNA indicated to Resident G that she could not help them because they already had been pulled up and already had pillows underneath them. Resident G indicated she needed to be pulled up more. Reluctantly, the unknown CNA and an unknown QMA pulled Resident G up to the very top of the bed. Resident G indicated it was better, but they wanted a rolled-up towel under their right hip so that they were off their wound that hurt. The unknown CNA continued to be frustrated with Resident G indicating she would not put a towel under them because it could cause a wound. After hearing what was going on from the hall, Registered Nurse (RN) 8 came into the room to help the unknown CNA. RN 8 placed a pillow under Resident G's right hip, and the resident indicated they were comfortable. RN 8 indicated she would let maintenance know about the resident's TV. The resident's call light was placed within reach, but the staff members left the resident's personal cell phone on the dresser in front of the bed. On 12/22/25 at 11:15 a.m. Resident G's family member came to visit the resident. She was very upset because the facility did not have her down as the first emergency contact, so she had not been notified of Resident G being discharged from the hospital or being admitted to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/22/25 at 2:10 p.m. Resident G was observed as they sat in their wheelchair in their room. The call light was not on. The resident was frantic and thankful someone had come to help them because the wound on their bottom hurt. Resident G had a pillow on the floor to their left, and their left arm was trapped between their body and the arm of the wheelchair. To Resident G's right there was a pillow between their body and the wheelchair, a pillow on top of the arm of the wheelchair and their left arm was dangling off the side of the wheelchair. Resident G was not sure how long they had been sitting there, but because of the swelling in their arms and hands, their right arm had become indented from where it was trapped. The resident's lunch tray was sitting on their bedside table out of reach. The liquids that were on the tray were a thin consistency. Resident G's call light was sitting on the bed out of reach of the resident at the time of the observation. Resident G had a new remote, but they indicated it did not work either, the news was playing on the TV. Upon observation, the new remote had the same issue as the previous remote had. The call light was pushed on behalf of the resident, an unknown CNA came to answer the call light, Resident G indicated they wanted to get back in bed. The CNA indicated she would go get linen to make the bed, then get the resident back in bed and tell maintenance about the TV again. On 12/22/25 at 11:35 a.m. Resident G's medical record was reviewed. They were a long-term care resident whose diagnoses included, but were not limited to, dysphagia (difficulty swallowing), functional quadriplegia (paralysis of all four extremities), and weakness. Resident G was admitted to the facility on [DATE] at approximately 4:00 p.m. Resident G had an active order to be in Enhanced Barrier Precautions (EBP) because they had an indwelling urinary catheter. Resident G had an active order for levothyroxine (a medication used to treat hypothyroidism) that indicated it was for hyperthyroidism. The Resident did not have hyperthyroidism or hypothyroidism listed as one of their diagnoses. Resident G had an active order for atorvastatin (a medication used to treat high cholesterol) that indicated it was for hyperlipidemia (high cholesterol). The Resident did not have hyperlipidemia listed as one of their diagnoses. The medical record lacked orders for Resident G's catheter use, catheter care, and parameters for the use of the catheter. The medical record lacked orders for Resident G's oxygen use, oxygen/respiratory care, and parameters of oxygen use. The medical record lacked orders for Resident G's code status. Hospital Speech therapy records, dated 12/19/25, indicated the hospital Speech Therapist (ST) recommended Resident G have no liquids with their meals, and only small sips of ice water between meals after strict oral care (Frazier Protocol). A progress note, dated 12/19/25, indicated Resident G arrived at the facility at approximately 4:00 p.m. with 1 to 2 liters of oxygen on through a nasal cannula, they had a wound on their tailbone and paralysis to both arms was noted. This note lacked documentation of Resident G having an indwelling urinary catheter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A clinical admission progress note, dated 12/19/25 at 10:01 p.m., indicated Resident G had her own teeth, was incontinent of bowel, had a size 14 French (fr) indwelling urinary catheter, they had impaired ROM to all four extremities, and they were non-weight bearing. A lift/transfer evaluation progress note, dated 12/19/25 at 11:47 p.m., indicated Resident G was non-weight bearing, did not have upper extremity strength and was not able to assist with repositioning in the bed or the chair. A skilled evaluation note, dated 12/20/25 at 7:34 p.m., indicated Resident G did not receive oral care because they were independent, there was no edema (swelling) was present, they were not incontinent of bowel, they had a size 16 fr indwelling urinary catheter, and they had no impairment in ROM for all four extremities. A skilled evaluation note, dated 12/20/25 at 9:02 p.m., indicated Resident G did not receive oral care because they were independent, no edema was present, no oxygen was in use, they were not incontinent of bowel, they had a size 16 fr indwelling urinary catheter and they had no impairment in ROM for all four extremities. In the vitals portion of the note, it indicated Resident G had 97% oxygen saturation on oxygen through a nasal canula. Resident G had an active care plan, initiated on 12/22/25, that indicated they were on EBP for an indwelling urinary catheter and wounds. The interventions for this care plan included but were not limited to catheter care as ordered and direct care staff would use gloves and a gown with all direct care. An inventory sheet, dated 12/22/25, indicated Resident G had their own clothes available to wear. This inventory sheet also indicated Resident G had upper and lower partial dentures. On 12/23/25 at 9:25 a.m. Resident G was observed as they lay in bed. An EBP sign was observed on the wall near the door that was not there the day before. The resident had on what appeared to be the same hospital type gown as the day before, they had a pillow under each arm, and they appeared crooked in bed. Resident G's breakfast tray was sitting next to them on the bedside table; it had not been touched. On the tray were several containers of thin liquids. During an interview on 12/23/25 at 10:57 a.m. LPN 7 indicated Resident G was only on EBP because they had a wound. The Infection Prevention (IP) nurse indicated they were also on EBP because they had an indwelling catheter. The LPN 7 indicated Resident G had a size 16 fr catheter. RN 8 indicated she had cleaned Resident G's catheter on all her shifts, because she knew you needed to keep them clean from when she worked in the hospital, but she did not realize there were no orders for the care of the resident's catheter. RN 8 indicated Resident G was incontinent of bowel, had a lot of edema at their baseline, and was dependent with all care including oral care. The LPN 7, the IP nurse and RN 8 all indicated they were not aware Resident G had upper and lower partial dentures. The LPN 7 indicated there were a lot of admissions the day Resident G was admitted , so she thought the nurses probably got the residents mixed up and charted the wrong things on some people, but she indicated the admitting nurse should have put in the standing orders for Resident G's indwelling urinary catheter, oxygen, and code status. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/23/25 at 12:33 p.m. the Rehab Director indicated they tried to evaluate newly admitted residents within 24 hours. Resident G's speech evaluation was done on 12/22/25 because no one was able to evaluate them over the weekend. The Rehab Director indicated it was their expectation that nursing staff would follow any hospital speech evaluation recommendations until the facility speech therapist was able to evaluate them. The Rehab Director indicated the admitting nurse should have put the order in for what the hospital speech therapist recommended for the resident's diet until the resident could be evaluated. During an interview on 12/23/25 at 12:41 p.m. the ST indicated they were still in the process of evaluating Resident G but they would most likely be recommending mildly thickened liquids. The ST indicated she had talked to the Dietary Director on 12/22/25 around lunch time and she indicated she would put a note on all future meal trays to only provide thickened liquids at meals. During an interview on 12/23/25 at 1:00 p.m. the Director of Nursing (DON) indicated it was her expectation that the admitting nurse put in all pertinent standing orders within their scope, and if they were unable to do that it was the expectation that they would pass it on to the next shift to be completed. At the time of exit a copy of a current facility policy titled, Charting and Documentation was provided. That policy indicated . All services provided to the resident, progress towards the care plan goals, or any changes in the residence medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . 2. The following information is to be documented in the resident medical record: a. Objective observations. c. Treatments or services performed. 3. Documentation in the medical record will be. complete, and accurate. 7. Documentation of procedures and treatments will include care specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care. At the time of exit a copy of a current facility policy titled, admission Assessment and Follow Up: Role of the Nurse was provided. That policy indicated . The purpose of this procedure is to gather information about the residence physical, emotional, cognitive, and psychosocial condition upon admission for the purpose of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS [Minimum Data Set]. Steps in the procedure. 7. Conduct an admission assessment (history and physical), including: c. A list of active medical diagnoses and patient problems (such as. impaired mobility), especially those most related to reasons for admission to the facility and those that are affecting function, nutrition, hydration, quality of life. d. Current medications and treatments. 10. Determine if the resident has existing advanced directives. if not, provide the resident with information on his/her rights to have advanced directives and initiate the process of establishing them. 11. Reconcile the list of medications from the medication history, admitting orders, the previous MAR [Medication Administration Record] (if available), and the discharge summary from the previous institution, according to established procedures This citation relates to Intake 2696487. B. On 12/22/25 at 10:39 a.m., Resident D observed to have lower leg edema with bandages covering his lower legs to help reduce edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/22/25 at 10:39 a.m., a record review was completed for Resident D. He had the following diagnoses which included, but were not limited to, low blood pressure, congestive heart failure, unstageable ulcer of his left heel, presence of cardiac pacemaker, muscle weakness, and multiple falls. He had a care plan intervention, dated 8/31/25, for no shoes on left foot for wound healing and ACE wraps, compression wraps toe to knee both legs for edema. On 10/23/25 at 1:47 p.m., his weight recorded was 224.0 pounds in a risk meeting note. The note indicated he was on daily weights due to fluid volume overload. As of the record review on 12/22/25, Resident D had a current physician orders for a daily weight and to call if weight greater than 3 pounds in 24 hours or 5 pounds in one week. On 12/4/25 his weight was 198.9 pounds and on 12/5/25 his weight was 205.0 pounds. Resident D gained 6. 1 pounds in a 24 hour period. Resident D's record lacked documentation that the physician was notified. On 12/15/25 his weight was omitted. A policy titled, Weight Assessment and Intervention, was provided by the Administrator on 12/23/25 at 3:45 p. m. It indicated, Residents are weighed upon admission and at intervals established by the interdisciplinary team. This citation relates to Intake 2681660. 3.1-37

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure proper infection control practices were used when caring for a resident who was in Enhanced Barrier Precautions (EBP) for 1 of 3 residents reviewed for infection control concerns (Resident G). Findings include:On 12/22/25 at 10:30 a.m. Resident G was observed in her room from the hallway. The resident was lying in bed calling out for help, the resident's call light was on at the time of the observation. Resident G had a catheter bag hanging on the side of their bed that was draining urine. There was no EBP sign on or around her door. The inside of Resident G's room was observed and there was no EBP sign in the room at the time of the observation. On 12/22/25 at 10:45 a.m. an unknown Certified Nursing Assistant (CNA) and an unknown physical therapy assistant were observed as they assisted Resident G with moving up in bed. Both staff members only wore gloves during the care they provided. On 12/22/25 at 11:00 a.m. the same unknown CNA and an unknown Qualified Medication Aide (QMA) were observed as they assisted Resident G with getting comfortable in bed. Both staff members only wore gloves during the care they provided. On 12/22/25 at 11:15 a.m. the unknown QMA left the room and RN 8 came in to assist the unknown CNA with adjusting Resident G. Both staff members only wore gloves during the care they provided. On 12/22/25 at 11:35 a.m. Resident G's medical record was reviewed. They were a long-term care resident who was admitted to the facility from the hospital on [DATE] at approximately 4:00 p.m. A clinical admission note, dated 12/19/25, indicated Resident G had a pressure ulcer on her coccyx (tailbone) and had an indwelling urinary catheter. On 12/23/25 at 9:25 a.m. Resident G was observed as she lay in bed. There was an EBP sign observed inside the resident's room. There was a Personal Protective Equipment (PPE) cart next to the room next door to Resident G's room, but not one next to the resident's room. RN 8 was observed helping Resident G with getting comfortable. RN 8 only wore gloves during the care she provided. During an interview on 12/23/25 at 10:57 a.m. LPN 7 indicated Resident G was only on EBP because they had a wound. The Infection Prevention (IP) nurse indicated they were also on EBP because they had an indwelling catheter. The IP nurse indicated gloves, and a gown should be worn any time someone would be in high contact with the resident. On 12/23/25 at 1:20 p.m. Resident G's catheter bag was observed laying on the ground next to the bed. At the time of exit a copy of a current facility policy titled, Policies and Practices- Infection Control was provided. That policy indicated .This facility's infection control policies and practices are intended to facilitate maintaining a safe, comfortable environment and to help prevent and manage transmission of diseases and infections. 2. The objective of our infection control policies and practices are to: a. prevent.infections in the facility. EBP was not discussed in this policy, and no other policy was provided. This citation relates to Intake 2696487. 3.1-18(b)