STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Robin Run Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to notify the Ombudsman of a discharge and failed to send a bed hold notification with the resident or to the family representative for 2 of 3 residents reviewed (Resident F and H). Findings include:1. On 3/31/26 at 1:00 p.m., a record review was completed for Resident H. She had the following diagnoses which included, but were not limited to, dysphasia (difficulty swallowing), dementia, and anxiety.A progress note, dated 3/9/26 at 11:38 a.m., indicated she was seen by the Nurse Practitioner and new orders were received to send resident to the emergency room (ER).The resident's record lacked notification of the Ombudsman, and a bed hold notice was not given to the resident and/or family representative.2. On 3/31/26 a record review was completed for Resident F. He had the following diagnoses which included, but were not limited to, Pick's disease (a rare form of dementia), aphasia (difficulty speaking), and repeated falls. A progress note, dated 3/1/26 at 7:45 a.m,. indicated Resident F was found on the floor in his room at 7:30 a.m. He was alert and awake, blood noted from a gash above his left eyebrow. He was able to move all extremities (arms and legs), no other trauma was noted after an assessment was completed. Resident was assisted to his wheelchair. His vital signs were obtained, and the ambulance was notified to transfer resident to the ER. The DON, primary physician and family were notified. Resident was picked up by an ambulance at 7:45 a.m.The resident' record lacked notification of the Ombudsman, and a bed hold notice was not given to the resident and/or family representative.On 4/1/26 at 2:38 p.m., the Director of Nursing indicated the Social Worker did not notify the Ombudsman and bed holds were not sent with residents and family representatives were not made aware of bed holds. On 4/1/26 at 1:40 p.m., a policy was requested for the discharge process, but it was not received before the exit conference.This citation relates to Intake 2807265.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews and record review, the facility failed to ensure appropriate baseline care plans (a required, preliminary care plan developed for nursing home residents within 48 hours of admission to ensure safe, effective, and person-centered care until a comprehensive care plan is finalized) were in place for a newly admitted resident (Resident J) within the required timeframe for 1 of 8 residents reviewed for baseline care plan implementation.Findings include:On 3/31/26 at 2:30 p.m. Resident J's medical record was reviewed. They were a long-term care resident whose diagnoses included, but were not limited to, bipolar disorder and hypertension (high blood pressure).A progress note, dated 3/28/26, indicated Resident J was admitted to the facility.On 4/1/26 Resident J's care plans were reviewed.Resident J's medical record lacked documentation of baseline care plans.During an interview on 4/1/26 at 11:24 a.m. the Director of Nursing (DON) indicated it was the facilities policy that within 48 hours a baseline care plan was to be put in place for all new admissions.On 4/1/26 at 12:44 p.m. a copy of a current facility policy titled, Care Plans- Baseline, undated was provided. That policy indicated, . A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.This citation relates to Intake 2799346.410 IAC (Indiana Administrative Code) 16.2-3.1-30(a)

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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** Based on record review and interview, the facility failed to ensure physician's orders were obtained for and treatments were provided for an enterocutaneous fistula (an abnormal passage between the bowel and the skin, allowing intestinal contents to leak onto the abdominal wall) while a resident awaited surgical intervention for the area for 1 of 3 residents reviewed for quality of care (Resident B). Findings include:Resident B's record was reviewed on 3/31/26 at 10:31 a.m. Census information indicated the resident was admitted to the facility on [DATE] and hospitalized on [DATE]. Diagnoses on the resident's profile included, but were not limited to, fistula of the intestine. A history and physical from the resident's previous hospital admission, dated 1/6/26, indicated the resident had an enterocutaneous fistula, required a wound care consult, and had been referred to the hospital for possible surgical intervention related to the fistula. A discharge summary report from the hospitalization on 1/6/26, indicated the resident had an enterocutaneous fistula that required surgical intervention. Due to the resident's ongoing need for skilled nursing care, and upcoming required surgical intervention, the resident would be admitted to a skilled nursing facility until the enterocutaneous fistula could be surgically repaired. Post hospital discharge requirements indicated, .Wound Care: Ongoing meticulous wound care for the enterocutaneous fistula until surgical intervention. An admission assessment, dated 2/12/26, indicated the resident had moisture associated skin damage on his abdomen around the stoma (opening on the abdomen that allows bodily waste to exit the body). A care plan, initiated on 2/12/26, indicated the resident had an alteration in intestinal status due to a fistula. Interventions included, but were not limited to, use ostomy appliance to manage fistula output. The care plan lacked documentation of specific treatment orders or instructions for when and how to treat the fistula and surrounding skin. A Nurse Practitioner (NP) progress note, dated 2/13/26, indicated to continue the ostomy bag over open wound, change as able, and follow up soon for surgical consult. The note lacked documentation orders were provided with specific parameters or instructions for treatment of the resident's fistula. A skilled progress note, dated 2/15/26, indicated the resident had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine through the surface to allow stool to exit the body). An NP progress note, dated 2/16/26, indicated to continue the ostomy bag over open wound, change as able, and follow up soon for surgical consult. The note lacked documentation orders were provided with specific parameters or instructions for treatment of the resident's fistula. An NP progress note, dated 2/18/26, indicated to continue the ostomy bag over open wound, change as able, and follow up soon for surgical consult. The note lacked documentation orders were provided with specific parameters or instructions for treatment of the resident's fistula. An NP progress note, dated 2/20/26, indicated to continue the ostomy bag over open wound, change as able, and follow up soon for surgical consult. The note lacked documentation orders were provided with specific parameters or instructions for treatment of the resident's fistula. A skin assessment, dated 2/20/26, indicated the resident had incontinence associated dermatitis to the abdomen. The assessment lacked documentation there was a treatment for the area. An NP progress note, dated 2/23/26, indicated to continue the ostomy bag over open wound, change as able, and follow up soon for surgical consult. The note lacked documentation orders were provided with specific parameters or instructions for treatment of the resident's fistula. An NP progress note, dated 2/25/26, indicated to continue the ostomy bag over open wound, change as able, and follow up soon for surgical consult. The note lacked documentation orders were provided with specific parameters or instructions for treatment of the resident's fistula. A skin assessment, dated 2/27/26, indicated the resident had redness around the stoma and fistula sites related to moisture associated dermatitis. The assessment lacked documentation of a treatment to the area. An NP progress note, dated 3/4/26, indicated to continue the ostomy bag over open wound, change as able, and follow up soon for surgical consult. The note (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lacked documentation orders were provided with specific parameters or instructions for treatment of the resident's fistula. Physician's orders, dated 2/12/26 to 3/6/26, lacked documentation of an order for treatment, care, or monitoring of the resident's fistula or a treatment for the moisture associated skin damage to the abdomen. Medication Administration Records (MARs) and Treatment Administration Records (TARs), dated February and March 2026, lacked documentation of treatment, care, or monitoring of the resident's fistula or the moisture associated skin damage on the abdomen. During an interview, on 3/31/26 at 2:02 p.m., the Director of Nursing (DON) indicated the resident had a fistula, not a surgically created ostomy. They had to use an ostomy bag over it because it oozed constantly. The resident needed surgical intervention. They should have kept the area clean and treated it with the ostomy appliances. During an interview, on 4/1/26 at 11:20 a.m., the DON indicated she was unable to find physician's orders for the treatment of the resident's fistula. There should have been physician's orders in place for treatments to the area. Physician's orders should have been obtained when the resident was admitted , and she was not sure how it was missed. On 4/1/26 at 12:40 p.m., the DON provided a document titled, Colostomy/Ileostomy Care, last revised in October 2010. The policy indicated, .Purpose: The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter.Steps in Procedure.8. When evaluating the condition of the resident's skin, note the following.b. Excoriation.Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the colostomy/ileostomy care was provided. 2. The name and title of the individual(s) who provided the colostomy/ileostomy care. 3. Any breaks in the resident's skin, signs of infection.or excoriation of the skin. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data. This citation relates to Intake 2799346. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, interview, and observations, the facility failed to implement interventions to treat pressure ulcers and failed prevent pressure to residents' bony prominences for 2 of 3 resident's reviewed (Resident H and G).Findings include:1. On 3/31/26 at 11:40 a.m. Resident H was not in her room. She had a regular mattress. A heel protector sat next to her bed on a fall mat. On 3/31/25 at 11:52 a.m., Resident H was observed sitting in her wheelchair, head down with her eyes closed in the Activity room. She was dressed appropriately with non-skid socks on, with her feet resting on her foot pedals. Staff assisted resident back to her room. Her heels were observed. The right heel skin was intact. The left heel's skin was a hard, black eschar (dead cells), measuring approximately 5 centimeters (cm) by 5 cm. Resident did not complain of pain. RN 6 was in the room and proceeded to wheel the resident out of the room without protecting her heel from pushing into her leg rest. On 3/31/26 at 1:00 p.m., a record review was completed for Resident H. She had the following diagnoses which included, but were not limited to, fracture of left femur (leg bone), dementia, and anxiety.On 3/13/26 at 10:44 p.m., a progress note indicated Resident H returned to the facility after a hospital stay for a fractured hip. The nurse documented resident left heel was mushy (soft and lacking firmness), with possible deep tissue injury (DTI) (a serious wound characterized by localized, purple/maroon discolored intact skin or blood-filled blisters, resulting from intense pressure or shear).On 3/13/26 at 11:28 p.m., a progress note indicated the resident's left heel was not open but noted it was mushy to touch.On 3/16/26 at 5:11 p.m., a progress note indicated a skin issue. New skin issue, left heel, laterally (side), unstageable (full-thickness wound where the base is covered making it impossible to determine the true depth or stage) presenting as DTI, measuring 3.13 cm by 2.78 cm. The note also indicated it was unknown how long the wound had been present. Education was provided to certified nursing aide (CNA) regarding caring for resident ensuring continuous off-loading of area when in bed, provider notified, and new order written for suspected deep tissue injury (SDTI) on the left heel.An order was received on 3/16/26 for betadine (medication to destroy or inhibit microorganisms and prevent infection) to be applied to the left heel three times daily (TID) for SDTI pressure ulcer, leave open to heal.On 3/31/26 at 5:11 p.m., a progress note indicated an assessment of left heel unstageable/SDTI. The wound measured 4.5 cm by (x) 4.3 cm, skin intact. Previously presented as a fluid filled blister. Fluid has reabsorbed. Wound was approximately 60% light pink/normal skin color and 40% black color. The surrounding skin was intact (closed) and normal skin color. Wound had evolved as expected. The plan was to continue the current plan of care, off-loading boot replaced to left foot after assessment. Right foot off-loaded using pillow under calf to keep outer ankle off the mattress. A care plan, dated 3/16/26, indicated the resident had a documented pressure ulcer. Location and staging were not mentioned. The goal, dated 3/16/26, indicated prevention of future pressure ulcers. The care plan lacked an intervention to off-load resident's heels.On 3/31/26 at 2:38 p.m., the DON was made aware that RN 6 had left the resident's heels pushing into the wheelchair pedals and that resident's heel protector was sitting in resident's room. She indicated the resident had re-admitted with a boggy, mushy heel. 2. On 3/31/26 at 10:59 a.m., Resident G was observed in bed with a fall mat to the left side of her bed. She had body pillows on both sides of her body. She had a low air loss (LAL) mattress that was set to the firmest setting. Her feeding tube was infusing Nutren (tube-feeding formula) as ordered. She was talkative.On 4/1/26 observed Resident G in bed with her eyes closed. Her LAL settings were at approximately 160. On 3/31/26 at 10:30 a.m., a record review was completed for Resident G. She had the following diagnoses which included but were not limited to age-related physical debility, hyperlipidemia (high cholesterol), dysphagia, major depressive disorder, respiratory failure, and generalized weakness. Resident G had a care plan, dated 9/17/25, indicating she was at risk for impairment to skin integrity due to decreased mobility with potential for friction and shear, moisture to skin, impaired sensory perception, enteral nutrition through the night and pleasure food for meals, bi-lateral (both) buttock shearing. The goal, dated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/17/26, indicated shearing to bilateral buttocks will heal by next review. An intervention, dated 9/17/25, indicated to use a draw sheet to avoid shearing. The care plan lacked an intervention for the use of a LAL mattress. On 4/1/26 at 11:10 a.m., during an interview with the Director of Nursing and Assistant Director of Nursing (ADON), the ADON indicated the resident's mattress setting should be set according to resident's weight. She was informed that the manufacturer's guideline cut off at page 7, therefore, it did not include the information she verbally provided. She indicated she would get the rest of the guidelines, but it was not received at the time of exit. A review of resident's weight in her medical record on 4/1/26 at 12:00 p.m. indicated she weighed 163.8 pounds. A policy titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol with a revision date of April 2018, was provided by the DON on 4/1/26 at 1:42 p.m. It indicated, .During the physician visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wound.The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions.410 IAC (Indiana Administrative Code) 16.2-3.1-40

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to prevent a fall with injury when they inappropriately transferred a resident (Resident H) resulting in actual harm of a hip and femur fracture, and when a resident's personal items were not within reach resulting in a fall with a brain bleed (Resident C) for 2 of 4 residents reviewed for falls resulting in a major injury.Findings include:1. On 3/31/25 at 11:52 a.m., Resident H was observed sitting in her wheelchair, head down with her eyes closed in the Activity room. She was dressed appropriately with non-skid socks on, with her feet resting on her foot pedals. On 3/31/26 at 1:00 p.m., a record review was completed for Resident H. She had the following diagnoses which included, but were not limited to, vertigo (dizziness), fracture of left femur (leg bone), essential hypertension (HTN), muscle weakness, dementia, and anxiety. Resident H had a care plan, dated 10/23/23, indicating she was at risk for falls related to gait/balance problems, had a diagnosis of dementia with impaired safety awareness, used a wheelchair, and had history of falls, unsteady gait (walking), and possible side effects from medications. The goal, dated 3/16/26, indicated she would have no major injury related to falls. An intervention, dated 10/16/23, indicated to encourage resident to lay down after breakfast and between meals. Another intervention, dated 10/6/23, indicated to assist resident to bed if she was noted to be restless or tired. She had an intervention indicating she needed prompt response to all requests for assistance. Resident H had a care plan, dated 10/3/23, indicating she had an Activities of Daily Living (ADL) self-care performance deficit for bed mobility, transfers, eating, and toileting related to limited mobility and has a history of dementia and may have fluctuation in daily ability to participate in her ADLs. A goal, dated 3/16/26, indicated she would have her needs met per staff interventions. Interventions, dated 10/3/23, indicated she required extensive assistant with toileting with 1 to 2 staff members for toileting needs, resident required total assistance of 2 staff members to move between surfaces and used a lift. Resident used a wheelchair. A review of her progress notes indicated, on 3/9/26 at 6:56 a.m., staff were providing care for resident and as they were trying to dress her, resident screamed out in pain of her left hip. She was assessed; the physician was notified and received orders for acetaminophen (Tylenol) 500 milligram (mg), two tablets by mouth and a left hip x-ray. A progress note, dated 3/9/26 at 11:38 a.m., indicated she was seen by the Nurse Practitioner and new orders were received to send resident to the emergency room (ER). A progress note, dated 3/9/26 at 11:49 a.m., indicated the nurse aide reported that resident was being weird while she was getting dressed for breakfast. The nurse went to assess and found the left hip warm to touch with no redness, and resident was unable to verbalize she was in pain. When the nurse lifted her leg off of the bed, resident grabbed toward her left hip and screamed ouch. The next progress note entered was on 3/13/26 at 10:44 p.m., indicating resident arrived back at the facility. She had 11 staples to the left upper lateral (side) hip surgical site and 5 staples to left lower lateral hip. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident's Minimum Data Set (MDS) dated [DATE] indicated she was severely impaired when it came to making decisions regarding tasks of her daily life. Staff were unable to complete a Brief Interview of Mental Status (BIMS) due to her cognitive loss. The Administrator reported an injury of unknown origin to the Indiana Department of Health (IDOH) on 3/10/26. The report indicated Resident H complained of pain in her hip area. The nurse assessed and when she lifted her leg to assess, the resident indicated she hurt. The Administrator initiated an investigation into causative factors. The resident's neck of left femur was fractured and an acute impacted femur intertrochanter fracture with [NAME] angulation of the fracture fragments. Acute nondisplaced left superior pubic ramus fracture. The follow up indicated injury of unknown origin. On 3/10/26 Certified Nursing Assistant (CNA) 10 provided a statement on the residents' fractures. She indicated she came in on Saturday morning (3/7/26). Resident H was still in bed. She tried to get resident up and the resident fell backwards into the bed. She then picked her up to transfer to the chair and she put her on the floor and she called Qualified Medication Assistant (QMA) 11 to help her get resident off the floor. On 3/23/26 at 3:19 p.m., a statement was received by QMA 11. She indicated she was doing her normal rounds on 3/7/26 when she was called to Resident H's room by CNA 10. CNA 10 asked QMA 11 to help her get Resident H off the floor. QMA 11 asked CNA 10 if resident fell and CNA 10 indicated, resident did not fall. She was heavy and had to lower her to the floor. She did not have immediate pain but later in the shift she started to complain of pain, and this was reported to Registered Nurse (RN) 9. On 4/1/26 at 1:18 p.m., the Unit Manager (UM) was interviewed. She indicated Resident H was a Hoyer lift. She indicated the incident happened over the weekend. She went to the resident's room, her legs were lying on one side of the bed. She barely touched her hip and she was immediately in pain. She was lowered to the floor over the weekend. She indicated they did not use assignment sheets. On 4/1/26 at 1:20 p.m., CNA 10 was interviewed via phone. She indicated Saturday on 3/7/26 before breakfast, Resident H was in bed. She had to get her up. She laid back in bed when attempting to transfer her. While she transferred the resident to the chair, the resident went down to the floor. The resident was having a problem with her leg. CNA 10 did not know the resident was having problems standing. She lowered the resident to the floor. She asked QMA 11 for assistance to pick the resident up. She indicated QMA 11 checked everything and resident was not in pain. Later in the day, Resident H was receiving a shower and when she was transferred to the shower chair, she was crying out in pain. She indicated she told the nurse and the nurse responded she would call the doctor. On 4/1/26 at 1:49 p.m., Licensed Practical Nurse (LPN) 5 indicated CNA 10 thought QMA 11 was a nurse. On 4/1/26 at 1:56 p.m., RN 9 reported she was not informed of resident being in pain on 3/7/26. She came in on 3/9/26 and staff reported to her that resident was in pain. She completed an assessment, including her vital signs, called the on-call team and informed them of resident guarding her leg and pain. The physician ordered Tylenol and a x-ray STAT. She called the family. She was in too much pain, so they sent her out to the ER. On 4/1/26 at 2:31 p.m., during an interview with QMA 11, she indicated CNA 10 asked her for help to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	get resident off the floor because she was heavy. They picked her up by placing their arms underneath resident's armpits and pulling her up with her pants. Resident had no abnormal behaviors. She doesn't talk only says hi and bye and blew her a kiss. She did not express any pain. She indicated she was with RN 9 counting narcotics when the resident's pain was reported. She indicated she told RN 9 to look at the resident for signs and symptoms of pain. On 4/1/26 at 2:38 p.m., during an interview with the DON, she indicated a resident lowered to the floor wasn't considered a fall. The DON was not present during the incident. She expected all staff to inform the nurse when a resident was lowered to the floor. She indicated she was lifted by one person when she should've been a mechanical lift. There were no assignment sheets, and she was working on creating assignment sheets for the staff. She indicated the resident should have been assessed before moving her. Staff need to anticipate her needs and be proactive instead of reactive. She indicated she would look for staff education regarding this incident. At the survey exit, no education was provided. She indicated a dementia resident should be checked every hour. She indicated the residents' cognition was moderately impaired. 2. On 3/31/26 at 12:00 p.m. Resident C's medical record was reviewed. They were a long-term care resident whose diagnoses included, but were not limited to, traumatic subdural hemorrhage (a life-threatening, often acute collection of blood between the brain and its outer covering). A progress note, dated 1/23/26 at 4:24 p.m., indicated an unknown Certified Nursing Assistant (CNA) and Resident C's roommate alerted Licensed Practical Nurse (LPN) 5 to Resident C's room. When LPN 5 arrived in the doorway she observed Resident C face down on the floor beside their bed. The note indicated Resident C had flipped off their bed when they tried to reach for their personal cell phone. LPN 5 assessed Resident C and observed a quarter sized knot on the left side of the resident's forehead. The note indicated Resident C was immediately sent to the hospital to be evaluated. A progress note, dated 1/24/26 at 4:36 p.m., indicated Resident C had been admitted with a diagnosis of an acute head injury (a sudden injury to the brain caused by an external force, such as a blow, jolt, or penetrating object, which alters brain function) with bilateral subdural hematomas (a life-threatening, often trauma-induced, accumulation of blood on both sides of the brain). Resident C's most recent Minimum Data Set (MDS) (a standardized, federally mandated clinical assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate resident functional capabilities, health needs, and preferences) assessment indicated they were dependent on clinical staff to help with all Activities of Daily Living (ADLs). Resident C had a care plan, dated 12/29/26, indicating they were at a high risk for falls. Interventions for this problem included but were not limited to, anticipate and meet the resident's needs, ensure personal items are within reach and a fall mat was placed on the floor next to the side of the bed. The record lacked documentation of what the resident's status was or if they planned to return to the facility or not. On 3/31/26 at 12:56 p.m. Resident C's daughter indicated when the resident arrived at the hospital after the fall on 1/23/26. She required immediate attention due to having several skull fractures and blood on their brain. She indicated Resident C was very frail and stayed at the hospital until the resident ultimately passed away on 2/14/26. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER: Robin Run Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/1/26 at 10:15 a.m. LPN 5 and Registered Nurse (RN) 6 indicated standard fall precautions for all residents, regardless of if they had had a fall or not, included, but was not limited to, ensuring the resident's personal items were within their reach. LPN 5 and RN 6 indicated they did that by keeping the residents things on their bedside table to the side of their bed. They indicated if a resident had limited range of motion and needed their personal items closer, they would put the items on the over the bed bedside table, so the items were right in front of them and easy to reach. During an interview on 4/1/26 at 11:24 a.m. the Director of Nursing (DON) indicated she agreed with LPN 5 and RN 6's explanation of standard fall precautions and what it meant to keep personal items within the residents' reach. During an interview on 4/1/26 at 12:15 p.m. LPN 5 indicated Resident C's CNA was in the room getting them situated on 1/23/26. After the CNA was done, she left and moved on to assist another resident. When the CNA left, she heard Resident C's roommate start to yell out to Resident C to stop moving around in bed or Resident C was going to fall. The CNA went to the door and yelled for LPN 5 to come quickly. When LPN 5 arrived at Resident C's door she indicated Resident C was observed lying face down on the floor, at the time LPN indicated it looked like the bedside table had been parallel to the bed instead of over her bed because when LPN 5 observed the Resident on the floor, Resident C was situated between the bed and the bedside table. LPN 5 indicated Resident C told her they were trying to reach their personal cell phone that was on the bedside table when they rolled off of the bed. LPN 5 could not remember if there was a fall mat next to Resident C's bed or not. LPN 5 indicated at the time of the fall, Resident C had recently gained a little more range of motion in their lower arms, but they had little to no control of them. She indicated from the elbows down Resident C could flop their arms where they wanted them to go, but it wasn't controlled. LPN 5 compared the resident's movements to a fish out of water, very floppy and uncontrolled. A policy titled, Falls and Fall Risk, Managing, was provided by the DON on 4/1/26 at 1:15 p.m. It indicated, .According to the MDS, a fall is defined as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of overwhelming external force (e.g. a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. This citation relates to Intakes 2706508 and 2807265. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)