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	06/01/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to protect a resident's right to be free from physical abuse and mental abuse by a staff member when the staff member roughly provided resident care and left the resident exposed without clothes while a non-caregiver observed via a video phone call without the resident's knowledge for 1 of 3 residents reviewed for abuse (Resident E). Using the reasonable person concept, it is likely the deficient practice would lead to psychosocial distress, anxiety, and/or fear. The deficient practice was corrected by 5/15/26 after the facility implemented a systemic plan and was therefore Past Noncompliance Findings include:On 5/29/26 at 11:00 a.m., the Administrator indicated the facility received a recording of a video call between Certified Nursing Aide (CNA) 22 and an unknown individual not employed by the facility. The facility received the video on 5/12/26 at 1:30 p.m. The investigation determined the recording occurred during the evening shift on 4/4/26. The video had no sound and was 2 minutes and 54 seconds in length. The Administrator provided a copy of the video call recording for review. The following events were observed on the video: At 00:01, CNA 22 positioned her phone on a surface directed at Resident E's bed. A small inset image in the lower left corner showed an unidentified person participating in the video call. At 00:07, CNA 22 moved the resident's legs from the footrest and grabbed the resident's left wrist, pulling her forward abruptly while placing her other hand behind the resident's neck and jerking the resident forward in her seat. At 00:16, CNA 22 placed her arms under the resident's arms and pulled her up from the wheelchair to a standing position. She used her left hand, while holding the resident up with her right arm, to pull down the resident's pants to her thighs. At 00:26 CNA 22 turned the resident to the right and seated her upright on the side of the standard height bed. She immediately turned away from the resident and moved forward to retrieve her phone. CNA 22 moved to the resident's bathroom with her back to the resident, leaving the resident out of CNA 22's sight and sitting upright on the side of the bed. At 00:36 CNA 22 placed her phone down, stepped back a few steps and turned her body to the side. She pulled her scrub top tightly to her abdomen at the bottom of her back and raised her other arm above her head. She could be seen speaking. She then turned her body, facing the other direction with her scrub top remaining tightened against her abdomen and her arm raised above her head and appeared to be speaking. At 00:42 CNA 22 picked up her phone and returned to the room, placing her phone down again. The resident could be seen sitting upright on the side of her bed. At 00:49 CNA 22 approached the resident and placed her right hand on the resident's back and her left arm to the back of the resident's knees and forcefully pivoted her to a lying position in bed. She removed the resident's pants. From 01:03 to 1:29, CNA 22's actions were mostly obstructed due to her position relative to the phone. She appeared to remove the resident's gown and unfasten her brief, and she tossed the gown to the floor. At 01:32, CNA 22 returned to her phone and looked at it. She then moved out of view, leaving resident in full view, lying in bed, with her breast exposed. She was completely unclothed except for her socks. Her knees were bent and partially obscured her lower abdomen/pelvis. The resident was observed moving her legs up and rubbing the back of her thighs with her hands. At 01:45, CNA 22 returned with a brief and gown. She pushed the resident to her right side abruptly and pulled her brief off the bed from under her right hip, exposing her buttock. She threw (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	the brief onto the floor. At 02:01, CNA 22 rolled the resident onto her back and secured a clean brief without performing peri-care. At 02:17, Resident E raised her left arm and touched the CNA's arm as the CNA continued to secure the brief on the resident. At 02:22, CNA 22 rolled the resident to her left side at the edge of the bed, with the resident supported against the CNA's thighs, and she repositioned something behind the resident. At 02:27, CNA 22 rolled the resident on to her back and pulled a gown over the resident's head abruptly. At 02:53, the video ends. A clinical record review for Resident E was completed 5/29/26 at 11:04 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, and malnutrition. A Lift/Transfer Evaluation, dated 4/28/26, indicated the resident was non-weight bearing and was not cooperative with transfers or repositioning. She was not able or partially able to assist with transfers from bed to chair. A health care plan, revised on 10/23/24, indicated Resident E had an activities of daily living (ADL) self-care deficit related to Alzheimer's disease. She was at risk for fluctuations day to day in ability to participate in her ADLs. Interventions included for her bed to be in low position when in bed, for assistance of two staff using a mechanical lift for transfers, and for two staff to assist with bed mobility. During a telephone interview on 6/1/26 at 2:13 p.m., Resident E's son indicated his mother had been a very private person and socially conservative. This exposure of her to anyone other than a caregiver would have devastated her. He chose not to review the video due to her exposure and was told there had been an investigation and CNA 22 was no longer employed by the facility. A current facility policy, revised April 2021, titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, provided by the Assistant Director of Nursing on 6/1/26 at 1:22 p.m., included the following: Policy Statement Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.Policy Interpretation and Implementation The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff. The deficient practice was corrected by 5/15/26 after the facility implemented a systemic plan and was therefore Past Noncompliance. The plan included the following actions: all interviewable residents were interviewed, non-interviewable residents had skin checks completed, and in-service training to staff on abuse, neglect, and resident rights was completed. Ongoing monitoring by Quality Assurance and Performance Improvement (QAPI) was implemented. This citation relates to Intake 3011816. 410 IAC (Indiana Administrative Code) 16.2-3.1-27(a)(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review, the facility staff failed to report an injury of unknown origin to the Administrator in a timely manner, which delayed the investigation for 1 of 5 residents reviewed for abuse and neglect. (Resident C)Findings include:A clinical record review for Resident C was completed on 5/28/26 at 11:26 a.m. Diagnoses included vascular dementia, osteoarthritis, osteoporosis, and a fracture of the fourth metacarpal bone in the left hand.A nursing progress note, dated 5/14/26 at 11:23 p.m., included a CNA had alerted the nurse that Resident C had complained about her left hand. Upon assessment, the nurse noted her left pinky and ring fingers were swollen and red and were painful to touch. The resident indicated she messed her hand up on her wheelchair. The provider was notified and an order was given to obtain an X-ray of her left hand.A nursing progress note, dated 5/15/26 at 7:23 a.m., included the Xray was completed and results were pending, and the nurse notified the daughter.The X-ray result, received on 5/14/26, indicated that the resident had an acute nondisplaced fracture to her fifth proximal phalangeal shaft.During an interview on 5/28/26 at 3:57 p.m., the Administrator indicated she had not been informed of Resident C's fracture until 5/20/26. She sent the incident report upon learning of the injury of unknown origin and started her investigation. She indicated the staff should have reported this on 5/14/26 upon learning the resident had an injury.A current facility policy, revised 4/2021, titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, left on the conference table during break on 5/29/26 and received at 2:04 p.m., included the following: .Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.This citation is related to Intake 3019913.410 IAC (Indiana Administrative Code) 16.2-3.1-28(c)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 observation and interview, the facility failed to ensure a resident with a full code and a change in condition was closely monitored and treated timely; and failed to ensure effective communication with hospice resulting in the resident having a delay in treatment and death for 1 of 3 residents reviewed for death (Resident B). The Immediate Jeopardy began [DATE], when a resident with a full code who had been alert and participating in her care, had an overall change of condition, the staff were unable to obtain labs, and the family had requested the resident be sent to the ER. The facility called Hospice and Hospice convinced the family to not send the resident to the ER. No Hospice assessment, admission, or contract had been obtained at that time. On [DATE] Hospice admitted the resident as a full code and ordered comfort medications. Comfort medications were not administered as ordered. On [DATE] the resident had a hard extended abdomen. The family was at bedside and concerned about the resident's condition. On [DATE] at 4:33 a.m., the resident had increased respirations, secretions, gurgling, and continued extended abdomen with no bowel movement since [DATE]. On [DATE] at 7:41 a.m., the facility called Hospice and indicated the resident was actively dying and a Hospice nurse was requested. On [DATE] at 9 a.m., the resident was found without respirations or pulse. The family was not notified of the resident's decline overnight on [DATE] to [DATE]. Vital signs were not obtained every 4 hours or on [DATE]. The Administrator (ADM), [NAME] President of Clinical Service (VPCS) via phone, and Regional Nurse were notified of the Immediate Jeopardy on [DATE] at 12:36 p.m. The Immediate Jeopardy was removed on [DATE], but noncompliance remained at a lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that was not Immediate Jeopardy. Findings include: An anonymous concern during the survey process indicated Resident B died on [DATE] when staff failed to initiate cardiopulmonary resuscitation (CPR) on her, even though she was a resident with full code orders. Resident B's clinical record was reviewed on [DATE] at 11:15 a.m. Resident B was admitted from an acute care hospital to the facility on [DATE] with diagnoses that included, but not limited to, schizoaffective disorder of the bipolar type (altered cognitive status with symptoms that included delirium, hallucinations, and behavioral symptoms), malignant neoplasm (cancer) of the pancreas, secondary malignant neoplasms of the liver and intrahepatic bile duct (the network of small, branching tubes located inside the liver), and constipation. A physician's order, dated [DATE], indicated the resident was full code (if your heart stops beating or you stop breathing, the medical team will attempt all possible life-saving interventions). The order was discontinued on [DATE], after the resident died. A physician's order, dated [DATE], indicated Glycolax Powder give 15 grams in 8 ounces of fluid by mouth every 24 hours as needed for constipation. An Indiana Physician Orders for Scope of Treatment (POST) form for Resident B, dated [DATE], indicated if the resident had no pulse and was not breathing, she wanted someone to attempt resuscitation/CPR. The treatment goal indicated the resident wanted full interventions including life support measures in the intensive care unit. In addition to care described in the Comfort Measures and Limited Additional Interventions sections, the resident wanted to use intubation, advanced airway interventions, and mechanical ventilation as needed. She wanted to transfer to the hospital and/or intensive care unit if indicated to meet medical needs. She wanted to use antibiotics consistent with treatment goals. Artificially administered nutrition would be decided at time of need. There was no documentation of optional additional orders. A clinical admission note, dated [DATE], indicated Resident B was alert and oriented to person, place, and time. The skin was warm and pink, and no edema was present. The abdomen was flat, non-tender, bowel sounds were present in all 4 quadrants, and the resident denied nausea, vomiting, diarrhea, constipation or bowel incontinence. A Dehydration Risk Evaluation, dated [DATE], indicated Resident B was not at risk for dehydration with a score of 2 on the evaluation. An admission Minimum Data Set (MDS) assessment, completed on [DATE], indicated Resident B had (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	moderately impaired cognition. She required supervision or touch assistance for eating, dressing her upper body, toileting hygiene, and propelling her manual wheelchair (WC) up to 50 feet. The resident was independent with bed mobility and partial/moderate assistance for transfers. The resident was occasionally incontinent of bladder, frequently incontinent of bowel, and had no constipation present. The resident had no symptoms of swallowing difficulties and had a weight gain of 5% or more in the past 6 months. Resident B and a family member participated in the assessment and goal setting. A care plan, dated [DATE], indicated Resident B had a full code status and the goal was to honor the resident's wishes of having a full code status. Interventions included administering CPR and following instructions on the POST form. A progress note, dated [DATE] at 4:14 p.m., indicated Resident B was admitted to the facility on [DATE] and resided on the secure memory care unit. The resident's oral intakes were documented as 75 to100 percent (%), and she required 1-person for the completion of activities of daily living (ADL's - bathing, dressing, eating, toilet use) and transfers. A Care Plan Conference Summary, dated [DATE], indicated Resident B participated in activities, consumed a regular diet, had no changes in her skin, and she had no medication issues. The resident made a special request to include fruits and salad at lunch and dinner. The advanced directives/code status was full code. The family stated they would like to transfer the resident to another facility with a private room. Resident B, the resident's guardian, a family member, and 4 staff members were documented/signed as being present. A late entry Risk Meeting Notes, effective, date [DATE] at 6:30 p.m., indicated Resident B continued to receive a no added salt (NAS) regular texture diet with thin liquids. She had bilateral lower extremity (BLE) edema unchanged from her admission status. The legal guardian/family member noted slight yellowing of the resident's eyes on [DATE]. Nurse Practitioner (NP) 4 was made aware of the guardian's concerns with the yellowing of the eyes and LE edema. NP 4 spoke with the guardian about care goals and options, and if the guardian did not want chemotherapy or radiation there was little that could be done beyond supportive care to ensure comfort. The nurse and NP 4 both spoke to the guardian about hospice as a goal of care for comfort and supportive care. NP 4 would continue to follow Resident B weekly. A progress notes by NP 4, dated [DATE], indicated she had discussed oncology with the guardian, who decided she did not want to pursue aggressive treatment. NP 4 discussed referring hospice and providing comfort measures only, and the guardian indicated she was willing to consider and discuss with the family. The resident was currently full code. Labs were attempted times 2 without success. Family discussed going to the ER for evaluation versus hospice. The plan included, cancel labs and KUB secondary to undergoing hospice and unable to get labs x 2 secondary to probable dehydration. Signed by NP 4 on [DATE] at 2:57 p.m. A late entry progress by Registered Nurse (RN) 13, created on [DATE] 6:51 a.m., effective date [DATE] at 4:00 p.m., indicated Resident B was observed to be weak on initial assessment, but her vital signs were within normal limits. The physician was notified and gave instructions to obtain labs and monitor her vital signs every 4 hours. The resident was observed with improved strength later in the shift. A progress note, dated [DATE] at 6:27 p.m., indicated Resident B's guardian requested that the resident be sent to the emergency room (ER) for evaluation and treatment related to the guardian's concerns for dehydration. The resident had an overall change of condition since her admission and was displaying a new baseline. The nurse called the hospice provider to inform them of the sister's wishes. A hospice representative provided education including pros/cons of sending the resident to the ER, and the guardian was in agreeance with not sending her to the ER at this time. NP 4 was informed of the situation. A progress notes by NP 4, dated [DATE], indicated the NP was informed by nursing that hospice was coming this date to evaluate the resident for admission to comfort care. Resident 4's code status was currently full code. Signed by NP 4 on [DATE] at 3:06 p.m. A progress note, dated [DATE] at 12:36 p.m., indicated Resident B was admitted to a local hospice with a diagnosis of colon cancer. New orders were received to give lorazepam (an antianxiety) 0.5 milligrams (mg) one tab every 4 hours as needed or wanted (prn), morphine (opioid) 100 mg/5 milliliters (ml) give 0.25 ml every 4 hours prn for pain and dyspnea (shortness of breath), (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	bisacodyl (laxative) 10 mg suppository one a day prn for constipation, acetaminophen (pain reliever) 650 mg suppository one every 6 hours for pain or fever, and hyoscyamine (a medication or substance used to relax muscles) 0.125 mg sublingual every 4 hours prn. The resident's guardian was present during the hospice admission. A progress note, dated [DATE] at 9:33 p.m., indicated Resident B's abdomen remained hard and distended and she still had not had a bowel movement. The family was at the bedside and concerned about the ineffectiveness of the last medication given to help with the bowel. Hospice was notified of the situation. A progress note, dated [DATE] at 10:41 p.m., indicated hospice responded to prior message and gave an order for a Fleet enema (saline laxative) times 1. A progress note, dated [DATE] at 4:43 a.m., indicated a change in condition was observed overnight with increased respirations and secretions, and the resident's abdomen remained distended without having a bowel movement during the shift. Hospice was notified and indicated they would be sending a nurse to the facility to evaluate the resident. A Medication Administration Note, dated [DATE] at 6:16 a.m., indicated Fleet Naturals Cleansing Enema 1 unit was ordered to be inserted until [DATE] at 11:59 p.m., was unavailable for administration. A progress note, dated [DATE] at 7:50 a.m., indicated Licensed Practical Nurse (LPN) 7 called the pharmacy for an update on morphine arrival. A pharmacy tech stated they had not received a script for the medication, and to follow up with hospice. A progress note, dated [DATE] at 8:07 a.m., indicated LPN 7 called the hospice group and requested a hospice nurse visit Resident B for further evaluation due to the resident's change in respirations. LPN 7 was told an on-call nurse would be sent to visit the resident. A progress note, dated [DATE] at 9:00 a.m., indicated LPN 7 was called to Resident B's room by Qualified Nursing Assistant (QMA) 10. Resident B's respirations and pulse had ceased. LPN 7 called and notified hospice and received a response that a nurse would be coming to the facility as soon as possible. A progress note, dated [DATE] at 9:30 a.m., indicated a hospice nurse arrived at the facility at 9:20 a.m., and stated she had notified the family of Resident B's passing and had called the funeral home to pick up the remains as ordered. The family was on the way to view the body. During the record review on [DATE], Resident B's clinical record lacked hospice documentation to include a hospice admission consent, hospice assessment, or a hospice plan of care. Resident B's clinical record lacked documentation that comfort medications ordered by hospice that included lorazepam, morphine, acetaminophen suppository or hyoscyamine were received by the facility or administered to the resident as ordered. The record lacked nursing documentation, from [DATE] - [DATE], to support a change in the resident's mental status, oral intake, bowel sounds were assessed, or nursing measures to help prevent dehydration or constipation. There was no documentation to indicate the primary MD/NP or Resident B's guardian had been notified of the resident's change in condition prior to death. Resident B's clinical record lacked documentation that vital signs were monitored every 4 hours per MD instructions. The last documented vital signs included on [DATE] at 7:52 a.m., respirations of 18 per minute and a temperature of 97.4 degrees Fahrenheit. On [DATE] at 7:44 p.m., a pulse of 90 beats per minute and a blood pressure of 92/65. On [DATE] at 7:40 a.m., oxygen saturations were 90% on room air. An Incident/Event form by the ADM, discovery date [DATE] at 11:45 a.m., indicated the alleged occurrence/incident requiring investigation included death of a resident who was a full code status and staff did not perform CPR. Resident had change in condition and hospice was notified and asked to come in to see resident at around 4:43 a.m. Hospice to send nurse to evaluate. At 8:07 a.m., hospice renotified and asked hospice to evaluate resident due to change in respiratory rate. At 9:00 a.m., called to room by CNA no respirations or pulse called hospice, they stated nurse would be there as soon as possible. Hospice nurse arrived at 9:20 a.m., called family, and she called funeral home.Final disposition, resident is deceased and staff will return to work. An Incident/Event Employee Incident/Event Investigation Statement by RN 9, dated [DATE], indicated on [DATE] the nurse came for her shift at 3:00 p.m. and was assigned to the memory care unit. When given report by the 1st shift nurse, she was told the resident had not had a bowel movement [BM] and her abdomen was distended. The 1st shift nurse reported that she had given the resident an ordered suppository. Family (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated they were concerned about the resident not having a BM since Saturday. RN 9 contacted hospice regarding the patient's situation. Hospice called back after an hour and gave a verbal order for a Fleet enema. The nurse put the order into the computer but was unable to find a Fleet enema in the pyxis (an automated medication dispensing system). RN 9 passed on the information to night nurse about the patient's situation. An Incident/Event Employee Incident/Event Investigation Statement by QMA 11, dated [DATE], indicated she had checked on the resident about 8:15 a.m. when breakfast came. An Incident/Event Employee Incident/Event Investigation Statement by QMA 10, dated [DATE], indicated she was on her way back from giving another resident her breakfast and when she checked on Resident B realized the resident was not breathing. QMA 10 called the resident's name and she did not respond. QMA 10 immediately ran and called for LPN 7. An Incident/Event Employee Incident/Event Investigation Statement by LPN 7, dated [DATE], indicated she walked into Resident B's room at 7:40 a.m. and the resident's breathing was shallow, her pulse was 50, and 02 sats were 90% on room air. LPN 7 was able to give a scheduled atropine as ordered. LPN 7 called hospice to notify them of the resident's condition. She then called the pharmacy to get an update on when morphine would be delivered and was told they never received a script. LPN 7 called hospice back and notified them of pharmacy not receiving a script. At 8:55 a.m., QMA 10 called her to the resident's room, and the resident was not breathing and no pulse was found. LPN 7 called hospice and the MD to notify them. The resident's record lacked documentation of the vital signs referenced on the incident investigation. A Witness Statement sent via email by LPN 8, dated [DATE], indicated during shift report last night, RN 9 informed her that it was reported that the day nurse noticed Resident B had abdominal distention and the resident had been given a suppository by day shift nurse per hospice orders. RN 9 then stated to LPN 8 that sometime during her shift she was notified the resident had still not had a BM, the abdominal distention was still present, and RN 9 notified hospice who gave orders to give a Fleet enema and monitor. RN 9 stated she couldn't find the Fleet enema, and it was not in emergency drug kit (EDK). LPN 8 stated that it may come with pharmacy when they came around 3:30 - 4:00 a.m., and she would monitor. Resident B was resting. Pharmacy arrived around 4:00 a.m. and did not deliver the resident's medication. LPN 8 noted a change in condition and gave a prn medication for secretions. Around 4:30 a.m., LPN 8 notified hospice that there was no Fleet enema on hand that was previously ordered, of the change in condition, and to get further instructions. Hospice said monitor and a nurse from the company would come to assess the patient's condition further. LPN 8 indicated she followed as ordered made a progress note, by shift change nurse reported to next nurse about patient condition and to be expecting the hospice nurse to come out because she hadn't come before I left. Followed hospice procedures and at no time were orders given for patient to be sent out! An Employee Suspension Pending Investigation Notice for LPN 7, dated [DATE]. The notice indicated the suspension was a result of an alleged or suspected violation or matter regarding misconduct or performance. Details of the current situation indicated Resident B was a full code on hospice. CPR was not performed when she was found expired. LPN 7 had been certified to perform CPR on [DATE]. An Employee Suspension Pending Investigation Notice for LPN 8, dated [DATE]. The notice indicated the suspension was a result of an alleged or suspected violation or matter regarding misconduct or performance. Details of the current situation indicated Resident B had a change of condition. Hospice was notified but had not arrived to the facility. The resident was not sent to the hospital. A typed interview with QMA 10, dated [DATE] at 1:15 p.m., indicated the interview was conducted by the Administrator and [NAME] President of Clinical Services 12 via phone. When the employee was asked what was the appearance of resident upon the employee noting resident without respirations, the QMA stated the resident was cool to touch and noted grayish color around her lips/mouth. Her lips were open, but her teeth were clenched. QMA 10 then notified the nurse on dayshift. A typed interview with RN 7, dated [DATE] at 1:28 p.m., indicated the interview was conducted by the Administrator and [NAME] President of Clinical Services 12 via phone. When asked if the resident showed (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	significant signs of rigor, RN 7 stated the resident's lips were parted but teeth/jaw appeared clenched. Noted gray pallor peri-oral. Resident was cool to touch. At that time, RN 7 notified hospice services. During an interview, on [DATE] at 10:30 a.m., Resident B's guardian indicated she had concerns regarding care for the resident during her stay and questions surrounding her death. The guardian indicated she had requested the facility assist in seeking alternative placement so the resident could have a private room, and although the family had agreed to admit the resident for hospice services, there was no expectation of imminent death, and the resident had remained a full code status. During an interview on [DATE] at 10:45 a.m., the Medical Record Supervisor indicated all medical records were scanned into the electronic medical record system versus being kept in paper-form. There had been no hospice documentation for Resident B available before he called with a request for copies on [DATE]. An admission Hospice Consent document for Resident B indicated, visit date [DATE]. There was no documentation of the resident having been visited by a hospice representative after the initial intake until after she died on [DATE]. The admission note indicated Resident B did not have a DNR order. The POA/Guardian verbalized agreement and understanding of patient rights and responsibilities. Patient code status is a full code with limited interventions. During an interview on [DATE] at 11:40 a.m., the Regional Director for a local hospice indicated, on [DATE], Hospice RN 17 had completed the hospice admission process with Resident B's guardian. Orders given for comfort medications should have been sent directly to the hospice Medical Director who should have given approval and signed off immediately. The orders were then sent to the facility pharmacy who were responsible for timely delivery. Residents were generally seen by a hospice nurse the day following admission to hospice and then scheduled bi-weekly routine visits. If a resident was deemed to be actively dying or imminent death, a nurse was scheduled to visit daily. A facility call after-hours would generate a follow-up by the on-call team for a prn visit, and the expectation was a 3-hour turn-around time. Resident B's hospice consents were signed electronically by the guardian and then a copy should have been sent to the guardian and facility electronically by the following business day. Hospice triage had been called on [DATE] at 7:00 p.m., to report a distended stomach and no relief/bowel movement after having been given a suppository, and responded at 8:30 p.m., with an order for a Fleet enema. Triage was called again on [DATE] at 1:30 a.m., to report Resident B had still not passed stool. On [DATE] at 5:00 a.m., triage logged a call from the facility requesting a nurse visit as the resident was experiencing an increased respiratory rate and gurgling, and Hospice RN 18 was assigned to go for a prn visit. On [DATE] at 7:41 a.m., triage logged a call from the facility stating Resident B was actively dying. Hospice documentation indicated Resident B had passed away around 9:15 a.m. before Hospice RN 18 arrived at the facility. The Regional Director indicated review of Resident B's hospice clinical record and the triage log for hospice indicated, there was no documentation a hospice visit was done from [DATE] when the admission process was completed, until after the resident's death on [DATE]. During an interview on [DATE] at 3:20 p.m., the ADM indicated on [DATE] she had received a call at home to inform her of Resident B's death. An investigation of the resident's death was initiated related to the resident being a full code and CPR was not performed. LPN 7 indicated she had not initiated CPR due to the resident being on hospice services, and her mouth showed the beginning signs of rigor to include her lips were parted, lips were discolored, she had grayish color around her mouth, and her skin was cool. Documentation indicated Resident B had not been observed by staff for approximately 2 hours before she was found dead. LPN 7 and RN 8 had been suspended pending investigation and had not yet returned to the schedule. Resident B's clinical record lacked documentation to support the ADM's statements. During an interview with NP 4 on [DATE] at 8:43 p.m., she indicated Resident B had been admitted to the facility on [DATE] with diagnoses of liver cancer but had been doing fairly-well. There was no expectation that the resident would have died within a month due to how she was presenting. NP 4 had visited Resident B on Friday [DATE], and the resident had been alert, sitting in a dining chair at a dining table in her room, and she was not having behaviors. The NP and Assistant (continued on next page)

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	06/01/2026

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing (ADON) met with the guardian who verbalized she did not want aggressive treatment for the resident, and the NP suggested hospice services. The guardian indicated she wanted to have a discussion with the family before deciding on hospice. NP 4 ordered repeat labs to be done on [DATE]. On Monday [DATE], the NP asked about lab results and was informed staff had been unable to get lab samples after 2 attempts. Resident B's condition was observed to be declining, and lab orders and a KUB order were discontinued by the NP after nursing staff indicated hospice services were being initiated that night. NP 4 indicated that was the last time she had a visit with the resident. On [DATE] at 8:15 a.m., facility staff had called NP 4 to request a morphine order, and NP 4 asked that they call hospice as she was enroute to another facility. NP 4 indicated neither she nor the primary MD had been made aware of the resident's change in status or rapidly declining condition after the visit on [DATE], and they had not been contacted with information regarding the facility not being able to get the resident's comfort medications or Fleet enema that had been ordered by hospice. During an interview on [DATE] at 7:27 a.m., QMA 11 indicated on Sunday [DATE], she had observed Resident B up in chair and she was alert. The resident was due to have more blood work. On Tuesday [DATE] when she worked again, the resident was actively dying, and staff did not get her out of bed. On Wednesday [DATE], she had gotten to work around 7:00 a.m. for her shift and had been assigned to work the floor as an aide. QMA 11 indicated the last time she saw Resident B was around 8:15 a.m. from the hallway as she was taking other resident to dining room for breakfast, and the resident had been breathing at that time. QMA 10, who was also working as an aide, had found Resident B unresponsive and went and got LPN 7. To her knowledge, vital signs had not been taken yet on the shift. QMA 11 and QMA 10 had been asked by the nurse to wash up the resident for presentation for the family. During an interview on [DATE] at 12:21 p.m., Unit Manager (UM) 20 indicated, on [DATE], there had been an order placed in Resident B's chart to admit her to hospice. UM 20 had spoken with a hospice representative who was in the facility and informed him that Resident B's guardian wanted the resident sent to the hospital. The hospice representative then spoke with the sister who was in the facility and called UM 20 back at 6:25 p.m. that evening and informed her that he had spoken to the guardian, and she agreed to leave the resident at the facility. The hospice representative indicated that the resident was in the works to admit to hospice, and to UM 20 that meant they would be coming on that date to sign the admission agreement with the family. LPN 7 and LPN 8 were unable to be reached for interview during the survey process. On [DATE] at 1:18 p.m., the ADM provided an Emergency Procedure-Cardiopulmonary Resuscitation, revised February 2018, and indicated the policy was the one currently being used by the facility. The policy indicated, General Guidelines.6. If an individual [resident, visitor, or staff member] is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: a. It is known that a Do Not Resuscitate [DNR] order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. There are obvious signs of irreversible death [e.g. rigor mortis]. The American Red Cross website, dated 2026, indicated Cardiopulmonary Resuscitation (CPR) can help save a life during cardiac arrest. When giving CPR, 1. If the person appears unresponsive, check for responsiveness, breathing, life-threatening bleeding or other life-threatening conditions using shout-tap-shout. 2. If the person does not respond and is not breathing or only gasping, call 911 and get equipment, or tell someone to do so. 3. Kneel beside the person. Place the person on their back on a firm, flat surface. 4. The American Red Cross CPR Guidelines recommends 100 to 120 chest compressions per minute, 30 at a time. Remember these 5 points: Hand position: two hands centered on the chest. Body position: shoulders directly over hands with elbows locked. Compression depth: at least 2 inches. Rate of compressions: 100 to 120 per minute. Allow chest to return to normal position after each compression. 5. Give 2 breaths. Open the airway to a past-neutral position using the head-tilt/chin-lift technique. Pinch the nose shut, take a normal breath, and make complete seal over the person's mouth with your mouth. Ensure each breath lasts about 1 second and make the chest rise, allow air to exit before giving the next breath. 6. Continue to give sets of 30 chest compressions (continued on next page)

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	155505	A. Building B. Wing	06/01/2026

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and 2 breaths. Use an AED as soon as one is available. Minimize interruptions to chest compressions to less than 10 seconds. On [DATE] at 1:18 p.m., the ADM provided a Guidelines for Notifying Physicians of Clinical Problems, revised [DATE], and indicated the policy was the one currently being used by the facility. The policy indicated, These guidelines are intended to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient and effective manner and that 2) all significant changes in resident/patient status are assessed and documented in the medical record.The following symptoms, signs and laboratory values [which are not all-inclusive] should prompt immediate notification of the physician, after an appropriate nursing evaluation. Immediate implies that the physician should be notified as soon as possible, either by phone, pager, text messaging, or other means. These situations include.2. Rapid decline or continued instability [for example, markedly fluctuating vital signs], unless the individual is receiving palliative care and has declined workup or treatment. 3. The following symptoms: a. Sudden in onset or a marked change [for example much more severe or frequent] compared to usual [baseline] status and are b. Unrelieved by measures which have already been prescribed and/or attempted. For example.abdominal pain with distension or fever.new or worsening confusion.4f. New and/or severe gastrointestinal signs, including prolonged and/or aggressive nausea and vomiting. Painful, persistent abdominal distention. A Hospice Program policy, dated [DATE], indicated, Hospice services are available to residents at the end of life.6. The agreement with the hospice provider will be signed by the facility representative and a representative from the hospice agency before hospice services are furnished to any resident. 7. A copy of the agreement is available through the facility business office and the hospice agency.9. In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including: a. Determining the appropriate hospice plan of care; b. Changing the level of services provided when it is deemed appropriate; c. Providing medical direction, nursing and clinical management of the terminal illness.e. Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. 10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual's needs. These include.c. Notifying the hospice about the following: [1] A significant change in the resident's physical, mental, social, or emotional status. [2] Clinical complications that suggest a need to alter the plan of care. [3] A need to transfer the resident from the facility for any condition. [4] The resident's death.12. Our facility has designated [blank space] to coordinate care provided to the resident by our facility staff and hospice staff.b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family. c. Ensuring that the LTC facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by other physicians The immediate jeopardy that began on [DATE] was removed on [DATE] when the facility had conducted a facility wide audit of all residents for POST forms, orders for code statuses, for documentation related to change of co

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	155505	A. Building B. Wing	06/01/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to implement timely interventions and treatments for residents who had pressure ulcers resulting in harm when those pressure ulcers worsened as a result of the lack of implementing interventions and treatments for 3 of 4 residents reviewed for pressure ulcers (Residents Q, L, and D). Findings include:1. On 6/1/26, at 10:15 a.m., the wife of Resident Q indicated she was concerned regarding Resident Q's care. She indicated that Resident Q was admitted to the facility, following a hospital stay, on 5/8/26 with intact skin. She indicated Resident Q had never had a pressure ulcer prior to his stay at the facility. Upon admission there was a Low Air Loss (LAL) mattress (a specialized medical-grade mattress used to prevent and treat bedsores) on his bed, but staff removed it, indicating his skin was intact and he didn't need it. On 5/26/26, physical therapy told Resident Q's wife they saw what appeared to be an open area on Resident Q's coccyx (tailbone). Up until that point no staff member had communicated any skin issues to her. On 5/31/26, she noticed Resident Q had some dark areas on his left ankle, left heel and left big toe and was able to provide pictures of the areas which confirmed her statement. He was then immediately provided with an LAL mattress and a wheelchair cushion. On 6/1/26, at 11:00 a.m., Resident Q's medical record was reviewed. Resident Q was a rehabilitation (rehab) resident whose diagnoses included type 2 diabetes, need for assistance with personal care, reduced mobility and generalized muscle weakness.Resident Q was admitted to the facility on [DATE], after a hospital stay from 5/4/26 to 5/8/26. The hospital discharge paperwork, dated 5/8/26, lacked documentation of the resident having had any skin issues prior to or during the hospital stay. On 5/8/26, the facility performed a Braden skin assessment (the most widely used evidence-based assessment tool to predict a patient's risk of developing pressure injuries) which showed Resident Q was at mild risk of developing a pressure ulcer. On 5/25/26, a wound assessment was completed which indicated Resident Q had a new pressure ulcer on his coccyx measuring 1.37 centimeters (cm) long by 1.76 cm wide and an area of Moisture Associated Skin Damage (MASD) (inflammation and erosion of the skin caused by prolonged exposure to moisture, such as urine, sweat, or wound drainage) on his coccyx measuring 1.47 cm long by 1.77 cm wide. The assessment lacked documentation of a description of the wound, what stage the wound was and a treatment plan for the wound. Based on the picture attached to that assessment, it appeared the pressure ulcer was to the right of Resident Q's coccyx and the area of MASD was to the left side of the coccyx, and the area of MASD appeared to be open from what could be seen in the picture. The record lacked documentation of treatment orders or preventative interventions related to Resident Q's newly acquired pressure ulcer and MASD from 5/25 until 5/28/26. The record lacked documentation that Resident Q's family had been notified of those new skin issues from 5/25 until 5/28/26. On 5/28/26, a wound assessment was completed which indicated the pressure ulcer and area of MASD on Resident Q's coccyx had merged into one large wound across the sacrococcygeal area (the region connecting the sacrum (the base of the spine) and the coccyx). That wound measured 5.6 cm long by 6.67 cm wide, was considered unstageable (a severe wound with full-thickness tissue loss where the true depth is hidden by dead tissue) and had a mixture of purulent (a thick, milky, or opaque fluid that oozes from a wound) and had serous (a clear or pale yellow, watery fluid that leaks from wounds during the healing process) drainage. Resident Q had an active order for an LAL mattress with a start date of 5/28/26. On 5/31/26, a wound assessment was started but indicated it was still in progress. The wound was still considered unstageable, but no measurements were documented on this assessment. A progress note, dated 5/31/26, at 6:27 p.m., indicated Resident Q had new suspected Deep Tissue Injuries (DTI) (a severe form of pressure injury that originates in the muscle layers closest to the bone) on the left heel, left big toe, and left 2nd and 3rd toes. Resident Q had active orders for pro heal critical care supplement (a liquid supplement used to promote wound healing), a wheelchair cushion and treatment orders for (continued on next page)

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	155505	A. Building B. Wing	06/01/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the sacrococcygeal pressure ulcer and DTIs to the left heal and left big toe all with a start date of 5/31/26. The record lacked documentation of a treatment order for suspected DTI to the left 2nd and 3rd toes.Resident Q had a care plan that indicated they had current wound orders and were at risk for further skin breakdown dated 5/31/26. The record lacked documentation of a pressure ulcer related care plan before 5/31/26. Resident Q had an active order for pressure-relieving boots with a start date of 6/1/26 at 3:00 p.m. During an interview on 6/1/26, at 12:10 p.m., the Assistant Director of Nursing (ADON) indicated she was also the wound nurse and oversaw the management of wounds in the facility. She indicated she was notified of an open wound on Resident Q's bottom on 5/25/26 by the floor nurse who was caring for the Resident on that shift. She indicated the Resident was getting ready to eat breakfast when she and the floor nurse went in to assess the wound initially. There was an open pressure ulcer to the right of Resident Q's coccyx and an area of what she determined was MASD to the left of his coccyx. The ADON indicated she told the floor nurse to put a hydrocolloid dressing (a waterproof, self-adhesive bandage containing gel-forming agents used to absorb minor wound fluid to create a healing environment that speeds up recovery and minimizes scarring) on the pressure ulcer and she would reevaluate the wound when she did her wound rounds. The ADON indicated she assumed the floor nurse would follow up with the Medical Director (MD) for orders, which she guessed was something she should not have done. She followed up during wound rounds on 5/28/26 where she indicated the pressure ulcer had gotten worse and merged with the area of MASD the Resident had, creating one large wound. The ADON indicated she was unaware of Resident Q's DTIs until 6/1/26. The Executive Director (ED) indicated she had noted them the previous day on 5/31/26. The ED indicated Resident Q had a DTI in the left outer area of the heel, on the tip of the left big toe and on the left big toe knuckle. The ED indicated Resident Q did not have any darkened areas or DTIs on the ankles when she observed him. 2. On 5/29/26, at 2:45 p.m., Resident L was observed as they were lying in bed resting with their eyes closed. The resident had their feet crossed at the ankles and their heels lying directly on the surface of the mattress. Resident L only had nonskid socks on their feet. On 5/29/26, at 3:00 p.m., Resident L's medical record was reviewed. They were a long-term care resident whose diagnoses included dementia and a pressure ulcer of unspecified site and stage. A progress note, dated 12/16/25, at 5:00 p.m., indicated Resident L arrived at the facility and noted that the resident had a pressure ulcer on their right heel from a busted blister and an intact fluid filled blister on their left heel. The note indicated there was a protective foam dressing on each heel from the hospital. An order was added on 12/19/25, for the floor nurse to cleanse Resident L's left heel wound with wound cleanser, pat dry, apply skin barrier to the peri wound (healthy skin surrounding the wound), apply a hydrofera blue dressing (a highly absorptive, antibacterial polyvinyl alcohol (PVA) foam dressing used to promote wound healing) to the wound bed and secure it with rolled gauze daily. The record lacked documentation of wound care orders for the pressure ulcer to the right heel. The record lacked documentation of wound care orders for the left heel before 12/19/25. A health status note, dated 12/26/25, indicated a referral to a wound care service was ordered. The order for the floor nurse to cleanse Resident L's left heel wound with wound cleanser, pat dry, apply skin barrier to the peri wound, apply a hydrofera blue dressing to the wound bed, and secure it with rolled gauze was discontinued on 12/26/25. An order was added on 12/26/25, for the floor nurse to cleanse Resident L's left and right heel wound with wound cleanser, pat dry, apply skin barrier to the peri wound, apply a xeroform (fine-mesh gauze pads or strips impregnated with petrolatum and 3% bismuth tribromo phenate), dressing to the wound bed, and secure it with rolled gauze daily. The record lacked documentation of any wound care orders for the right heel before 12/26/25. A skin issue note written by a contracted wound care provider, dated 1/3/26 for an assessment done on 1/2/26, indicated Resident L had a pressure ulcer on their left heel and a Deep Tissue Injuries (DTI) (a severe form of pressure injury that originates in the muscle layers closest to the bone) on their right heel. The description of those wounds was as follows: wound one was a stage 3 pressure ulcer (a serious, deep wound characterized by full-thickness skin loss where (continued on next page)

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	155505	A. Building B. Wing	06/01/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	subcutaneous fat is usually visible, but underlying muscles, tendons, or bones are not exposed) on the left heel that measured 6 cm long by 4 cm wide by 0.1 cm deep that was identified on 12/26/25 and developed while the resident resided in the facility. The treatment to be ordered for wound one was for the floor nurse to apply collagen (a wound dressing that stimulates the bodies natural healing process.), a bordered dressing (a wound dressing that features a central, non-adherent absorbent pad surrounded by an adhesive border), apply rolled gauze to cover and an ace wrap for compression. Wound two was a suspected DTI on the right heel that measured 5 cm long by 4.5 cm wide and was 75% eschar (dead tissue). The treatment to be ordered for the suspected right heel DTI was for the floor nurse to paint the wound bed with betadine (a broad-spectrum, over-the-counter topical antiseptic used to kill bacteria, fungi, and viruses to prevent infections), let it dry, apply an Abdominal (ABD) pad (a multi-layer, highly absorbent medical dressing used to cover, cushion, and protect large or heavily draining wounds), rolled gauze and an ace wrap for compression. It was requested to offload Resident L's heels by providing a Low Air Loss (LAL) mattress (a specialized medical-grade mattress used to prevent and treat bedsores) and apply pressure relieving boots when the resident was in bed. The record lacked documentation of an order for the wound care requested by the contracted wound care provider for Resident L's left and right heel wounds, an order for the requested LAL mattress, or an order for requested pressure relieving boots being added after the assessment on 1/3/26. A skin issue note written by a contracted wound care provider, dated 1/9/26 for an assessment done on 1/9/26, indicated Resident L had a pressure ulcer on their right heel and a DTI on their left heel. The description of those wounds was as follows: wound one was a stage 3 pressure ulcer on the right heel that measured 5 cm long by 8.5 cm wide by 0.2 cm deep that was identified on 12/26/25 and developed while the Resident resided in the facility. The treatment to be ordered for wound one was for the floor nurse to apply collagen, a 4X4 gauze pad to the wound, apply rolled gauze to cover and an ace wrap for compression. Wound two was a suspected DTI on the left heel that wasn't measured. The treatment to be ordered for the left heel DTI was for the floor nurse to apply xeroform, apply an ABD pad, rolled gauze to cover and an ace wrap for compression. It was again requested to offload Resident L's heels by providing an LAL mattress and apply pressure relieving boots when the Resident was in bed. The record lacked documentation of an order for the wound care requested by contracted wound care service for Resident L's right heel wound, an order for the requested LAL mattress, or an order for requested pressure relieving boots being added after the assessment on 1/9/26. A skin issue note written by a contracted wound care provider, dated 1/17/26, for an assessment done on 1/16/26, indicated Resident L had a pressure ulcer on their right heel and a pressure ulcer on their left heel. The description of those wounds was as follows: wound one was a stage 3 pressure ulcer on the right heel that measured 2 cm long by 2 cm wide by 0.1 cm deep that was identified on 12/26/25 and developed while the resident resided in the facility. The treatment to be ordered for wound one was for the floor nurse to apply Santyl (a prescription ointment used to remove dead tissue from chronic skin ulcers) to the wound bed, apply calcium alginate (a highly absorbent, non-woven wound dressing made from natural brown seaweed or kelp) to the wound, wrap with rolled gauze to cover and an ace wrap for compression. Wound two was a DTI that turned into a stage 3 pressure ulcer on the left heel that measured 2 cm long by 3 cm wide by 0.1 cm deep was identified on 1/16/26 and developed while the resident resided in the facility. The treatment to be ordered for wound two was for the floor nurse to apply xeroform, apply an ABD pad, rolled gauze to cover and an ace wrap for compression. It was requested to offload Resident L's heels by providing an LAL mattress and apply pressure relieving boots when the Resident was in bed for a third time. An order was added on 1/17/26, for the floor nurse to apply skin prep to the peri wound of Resident L's right heel wound apply Santyl to the wound bed, apply calcium alginate to the wound, wrap with rolled gauze to cover and an ace wrap for compression daily. The record lacked documentation of an order for the requested LAL mattress or an order for requested pressure relieving boots being added after the assessment on 1/17/26. A skin issue note written by the contracted wound care service provider, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	dated 1/23/26 for an assessment done on 1/23/26, indicated Resident L had a pressure ulcer on their right heel and a pressure ulcer on their left heel. The description of those wounds was as follows: wound one was an unstageable pressure ulcer on the right heel that measured 3 cm long by 2.5 cm wide by 0.2 cm deep that was identified on 12/26/25 and was developed while the Resident resided in the facility. The treatment to be ordered for wound one was for the floor nurse to apply Santyl to the wound bed, apply calcium alginate to the wound, wrap with rolled gauze to cover and an ace wrap for compression. Wound two was a stage 3 pressure ulcer on the left heel that measured 2 cm long by 3 cm wide by 0.1 cm deep that was identified on 1/16/26 and developed while the Resident resided in the facility. The note indicated the cap (the top layer of skin, which typically presents as a dry, firm, or boggy eschar (a scab-like, dark-colored covering or a thick, blood-filled blister) fell off the wound revealing red exposed dermal layer. The treatment to be ordered for wound two was for the floor nurse to apply xeroform, apply an ABD pad, rolled gauze to cover and an ace wrap for compression. The note indicated the unstageable pressure ulcer on Resident L's right heel had worsened since the last assessment and they may need to do sharp debridement (a medical procedure that uses sterile surgical instruments to carefully remove dead, damaged, or infected tissue from a wound bed) when the Resident was to be seen next. The note indicated a lidocaine patch would need to be placed on the wound 30 minutes to one hour before wound rounds to numb the area. It was requested to offload Resident L's heels by providing an LAL mattress and apply pressure-relieving boots when the Resident was in bed. The record lacked documentation of an order for the requested LAL mattress or an order for requested pressure relieving boots being added after the assessment on 1/23/26. A skin issue note written by the wound care service provider, dated 1/30/26 for an assessment done on 1/30/26, indicated Resident L had a pressure ulcer on their right heel and a pressure ulcer on their left heel. The description of those wounds was as follows: wound one was an unstageable pressure ulcer on the right heel that measured 2.5 cm long by 2.5 cm wide by 0.3 cm deep that developed on 12/26/25. The treatment to be ordered for wound one was for the floor nurse to apply Santyl to the wound bed, apply calcium alginate to the wound, wrap with rolled gauze to cover and an ace wrap for compression. Wound two was a stage 3 pressure ulcer on the left heel that was considered healed upon assessment. The treatment to be ordered for wound two was for the floor nurse to apply skin prep to the healed areas to prevent reopening. The note indicated the unstageable pressure ulcer on Resident L's right heel had worsened since the last assessment and they planned to do a sharp debridement next assessment due to the requested lidocaine patch not being ordered or applied before wound rounds on that assessment. The note indicated again a lidocaine patch would need to be placed on the wound 30 minutes to one hour before wound rounds to numb the area. It was requested to offload Resident L's heels by providing an LAL mattress and apply pressure relieving boots when the Resident was in bed. The record lacked documentation of an order for the requested LAL mattress or an order for requested pressure relieving boots being added after the assessment on 1/30/26. The order for the floor nurse to cleanse Resident L's left and right heel wound with wound cleanser, pat dry, apply skin barrier to the peri wound, apply a hydrofera blue dressing to the wound bed and secure it with rolled gauze was discontinued on 1/30/26.The order for the floor nurse to apply skin prep to the peri wound of Resident L's right heel wound apply Santyl to the wound bed, apply calcium alginate to the wound, wrap with rolled gauze to cover and an ace wrap for compression was discontinued on 1/30/26. From 1/17/26 until 1/30/26, there were two separate orders for different types of wound care to be applied daily An order for Resident L to float their heels while in bed using pressure relieving boots was added on 4/3/26. At the time of exit, the record lacked documentation of an order for the requested LAL mattress. 3. On 5/29/26, at 11:00 a.m., Resident D's medical record was reviewed. They were a memory care resident whose diagnoses included dementia, type 2 diabetes, pressure ulcers to the left and right heels and need for assistance with personal care. Resident D was admitted to the facility on [DATE] from a hospital stay. Hospital discharge paperwork, dated 3/17/26, indicated the hospital ordered wound care instructions were as (continued on next page)

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	06/01/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	follows: twice a day or after incontinence episodes the floor nurse was to cleanse the buttock and perineal [the space between the anus and the genitals] area with baza cleanse and protect (an all-in-one, no-rinse perineal lotion), pat dry and apply a thin layer of critic aide moisture barrier paste (a high-performance moisture barrier ointment designed to protect, treat, and heal skin irritation) to the area. The instructions included preventative measures that were to have been put in place upon admission that included but were not limited to providing an LAL mattress for the resident. The record lacked documentation of an order for the requested treatment for Resident D's buttock and perineal area. The record lacked an order for an LAL mattress as requested in the hospital discharge instructions. An admission assessment, dated 3/17/26, indicated Resident D did not have any skin abnormalities. An admission Minimum Data Set (MDS) assessment, dated 3/17/26, indicated Resident D was at risk for pressure ulcers. A progress note, dated 3/17/26, indicated Resident D was being admitted to the facility for a rehab stay and they had wounds on both lower extremities and a rash on their perineal area and bottom. A physician's note, dated 3/21/26, indicated Resident D had chronic wounds (a wound that does not heal in an orderly, timely manner) on both lower extremities and the wound care team would see the resident. A progress note, dated 3/24/26, indicated Resident D had a new skin tear on her coccyx that measured 2.22 cm long and 2.18 cm wide. A skin issue note written by a contracted wound care provider, dated 4/4/26, indicated Resident D had an initial assessment of several wounds, some new and one identified prior to the provider seeing the resident. The description of those wounds included but was not limited to as follows: Skin issue three was a new unstageable pressure ulcer on Resident D's right heel that measured 4 cm long by 3 cm wide by 0.1 cm deep, was 67-100% dead tissue and was identified on 4/3/26 while the resident resided in the facility. Skin issue one was a stage 2 pressure ulcer on Resident D's coccyx that measured 1.41 cm long by 1.73 cm wide and developed on 4/3/26 while the resident was at the facility. An order was added on 5/14/26 for an LAL mattress. During an interview on 5/29/26, at 12:30 p.m., the ADON indicated the wound on Resident D's coccyx was initially assessed as a skin tear by someone, she wasn't sure who, however upon reviewing the photo taken at the time of the assessment she would not have considered it a skin tear, it looked like an open area in her opinion. On 5/29/26, at 1:18 p.m., a copy of a current facility policy titled Prevention of Pressure Injuries, dated 4/2020, was provided. That policy indicated, . The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Skin Assessment. 1. Conduct A comprehensive skin assessment upon (or soon after) admission. Prevention. 4. Use a barrier product to protect skin from moisture. Support Surfaces and Pressure Redistribution 1. Select appropriate support surfaces based the residents risk factors. Monitoring. 2. Review the interventions and strategies for effectiveness on an ongoing basis. On 5/29/26, at 1:18 p.m., a copy of a current facility policy titled Pressure Ulcers/Skin Breakdown- Clinical Protocol, dated 4/2018, was provided. That policy indicated, .Assessment and Recognition. 3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. Treatment/Management. 1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorbative, etc.), and application of topical agents. This citation is related to Intake 29757009 and 3031446. 410 IAC (Indiana Administrative Code) 16.2-3.1-40