STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00445487, and Complaint IN00445724. Complaint IN00445487 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00445724 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: November 13, 14, and 15, 2024 Facility number: 001156 Provider number: 155505 AIM number: 100453350 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 13 Medicaid: 26 Other: 18 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 27, 2024.	F 0000	Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during our recent complaint Survey at Robin Run Village. Hopefully, you will find our remedies to be both sufficient and thoroughly explained. The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. We are requesting Paper Compliance Review with the submission of these remedies. If after reviewing the plan of correction you have any questions, please do not hesitate to contact us.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices A. Based on observation, interview, and record review, the facility failed to ensure a resident with	F 0689	p paraid="43939394" paraeid="{21168a16-4b89-4af6-8dd	12/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Bledsoe	Executive Director	12/13/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a history of fall-related fractures was transferred with two staff persons in accordance with the plan of care, and failed to ensure post fall procedures were followed for 1 of 3 residents reviewed for falls (Resident D). This deficient practice resulted in a fall while in the shower room and the resident sustained fractures of two left ribs, the spine, and the sacrum. B. Based on interview, observation, and record review, the facility failed to ensure cleaning chemicals were stored in a manor to prevent residents from accessing them for 1 of 3 residents reviewed for accidents, with the potential to effect 19 of 19 residents residing on the secured memory care unit (Resident K). Findings include: A. During a confidential interview conducted during the survey, the interviewee indicated Resident D fell, and her family took her to the hospital where she was found to have two broken ribs. Resident D's record was reviewed on 11/13/24 at 3:00 p.m. Diagnoses on Resident D's profile included, but were not limited to, muscle weakness, difficulty walking, and repeated falls. A physician order, dated 5/31/24, ordered 1 tablet daily of Sertraline (antidepressant) HCI 50 milligrams (mg) for depression. The National Institute of Health (NIH) indicated studies reported serotonin uptake inhibitors (SRRIs) were associated with an increased risk of falls in the elderly. The admission and state optional MDS (Minimum Data Set) assessments, completed on 6/6/24,		8-fe99de71236d}{62}" >F689 Accident Hazards and Supervision Resident(s) affected by alleged deficient practice: Resident D was newly admitted to the facility 5.31.24 after admission to the hospital 5.27.24 from home where she lived with son. Per the hospital H&P dated 5.27.24 Res D was complaining of pain from a fall at home. X-rays revealed no acute fractures () but were “difficult to determine due to low bone density” and was treated with antibiotics for a urinary tract infection. According to hospital H&P res D was not treated for a fracture or surgical intervention as stated. However, Res D did have a history, noted on H&P of displaced of right humerus with routine healing, closed displaced comminuted of shaft right fibula with routine healing and other of upper end right tibia subsequent closed with routine healing, when living at home, prior to admission to facility. There were no dates noted for these fractures. H&P stated residents lived at home alone with their son prior to 5.27.24 hospital admission. After admission to the facility, Res D was diagnosed, in the facility per doppler study, with a DVT (blood clot) to the right leg due to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessed Resident D as usually having the ability to make herself understood and to understand others. A brief interview for mental status (BIMS) score of 10/15 indicated she had moderately impaired cognition. The resident required extensive assistance of two plus (+) persons physical assist for bed mobility, transfers, and extensive assistance of one person physical assist for toilet use. Mobility devices included a manual wheelchair (WC) and walker. Resident D had no falls in the 6 months prior to admission. The admission and state optional MDS (Minimum Data Set) assessments, completed on 6/6/24, did not reflect the resident's recent fall with fractures requiring hospitalization and surgical repair 5/27/24. Fall Risk Data Collection assessments, dated 6/1/24 and 6/10/24, indicated no falls in the last 90 days. The Fall Risk Data Collection assessments, dated 6/1/24 and 6/10/24, did not reflect the resident's recent fall with fractures requiring hospitalization and surgical repair on 5/27/24. A late entry progress note, effective date 5/31/24 at 8:51 p.m., indicated the resident was admitted to the facility via ambulance. She was total care, required extensive assistance with all activities of daily living (ADL's), and all transfers were done with 2 staff members. A care plan, dated 6/3/24, indicated the resident was at risk for falls related to history of falls, impaired vision, use of WC, and decreased mobility with possible side effects from medications. The goal was for Resident D to be free from falls through the next review.		multiple comorbidities and history of without surgical repair to the right fibula and right tibia and treated in house. Res D was being administered (blood thinner) prior to admission to facility and during stay. The side effect of is bruising. Res D Developed cellulitis 8.10.24_and receiving antibiotic treatment in facility. “Family notes interval worsening of edema and increased discoloration since 8/10/2024.” Prior to the fall 8.14.24 the NP evaluated res with following findings, “Approx 2cmx2cm firm, superficial subcutaneous nodule on LUQ, RLE with 2-3+ edema and purple/red discoloration around R knee and extending into calf.” Res D was transferred to hospital on 8.15.24 and did not return to the facility. Prior to survey, LPN 9 no longer works at facility. Res K was assessed by the Director of Nursing (DON) and did not find signs/symptoms/evidence that res K had ingested the cleaning chemical and when questioning staff no one saw Res K ingest. DON and nurse contacted the nurse practitioner, on call for the physician, and poison control, as directed. Poison control advised actions to provide milk which was done by staff and no negative outcome noted to Res K. Chemicals	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interventions included call light within reach and encourage resident to use it, educate resident/family/caregivers about safety reminders and what to do if falls occur, ensure resident wore proper footwear, follow fall protocols, physical therapy (PT) to evaluate and treat as ordered or needed, and review information on past falls and attempt to determine cause of falls. Record possible root causes, alter/remove any potential causes if possible. The care plan, dated 6/3/24, did not reflect the resident required extensive assistance of two plus (+) persons physical assist for bed mobility, transfers, and extensive assistance of one person physical assist for toilet use requiring extensive 2 person physical assistance for transfers as indicated in the admission and state optional MDS (Minimum Data Set) assessments, completed on 6/6/24. A physician order, dated 7/1/24, ordered the resident to continue participating in skilled occupational therapy (OT) intervention to address deficits in strength, balance, transfers, and ADL performance. A physician order, dated 8/13/24, ordered 1 tablet daily of Cyanocobalamin (a form of Vitamin B12) 100 milligram (mg) related to difficulty walking. A physician order, dated 8/13/24, ordered 1 tablet daily every 2 days of Ferrous Sulfate (used to treat iron deficiency anemia) 325 mg related to muscle weakness. A progress note, dated 8/14/24 at 3:15 p.m., indicated Resident D had returned from an emergency room (ER) visit, on antibiotics (ATB) for right lower extremity (RLE) cellulitis, to be		identified during survey in unlocked, unsupervised area on the memory care unit were immediately removed and education was provided by the administrative staff regarding chemicals. Res K care plan updated for keeping chemicals out of reach by the Memory Care clinical nurse. Residents at risk for the alleged deficient practice(s): All residents on the Memory Care Unit could be affected by chemicals being left unattended in Memory Care resident care areas; and ·Residents with assistance of 2 staff for transfer could be affected by alleged deficient practice; The facility nursing admin will review all in house residents' transfer status and care plans to ensure appropriate transfer status is indicated, including interventions. ·Systems to ensure alleged deficient practices do not recur; Staff will be provided with education by the DON/designee/housekeeping supervisor regarding chemical safety in resident care areas, ensuring areas where chemicals	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	completed in 3 days. Therapy evaluated for leg position for comfort, family at bedside, no further concerns noted, and call light was within reach. A History and Physical note, dated 8/14/24, the Nurse Practitioner (NP) indicated Resident D was readmitted to the skilled nursing facility (SNF) on 8/13/24 following hospitalization on 8/12/24 for RLE discoloration and edema. The resident was completing a course of cephalexin (Keflex antibiotic) for RLE cellulitis. Prior to this, she was admitted to SNF on 5/31/24 following hospitalization from 5/27/2024 for a fall. A progress note, dated 8/15/24 at 8:00 a.m., indicated Resident D's daughter requested that her mother be sent to the ER for evaluation post fall that occurred on the evening of 8/14/2024. Head to toe assessment completed. No injury noted. The resident complained of hitting her head and that her left ribs were hurting. Resident skin warm and dry, no distress noted. Alert and responding verbally. A progress note, dated 8/15/24 at 9:00 a.m., indicated emergency transport arrived to transport resident to (a local hospital) for evaluation and treatment, the family accompanied resident to hospital. Transfer medical paperwork sent with emergency medical services (EMS). Resident transported by stretcher. A late entry progress note, effective date 8/15/24 at 9:20 a.m., created 8/16/24 at 8:13 a.m., the Director of Nursing (DON) documented discoloration noted to RLE, no redness, no drainage, no open areas noted, +1 pitting edema noted, continue ATB for cellulitis of RLE, added note to previous note regarding skin. Previous late entry notes 8/15/24 resident left to local		are located are secured, doors to non-resident care areas are locked and or housekeeping carts are locked when not attended, chemicals for resident care or cleaning are secured. Education will be provided by the DON/designee/Housekeeping supervisor, staff not receiving education by compliance date must receive education prior to working. This training will be provided during staff orientation and as indicated ongoing by the DON/department supervisors/designee. ·Nursing staff/licensed nurses will be provided with education by the DON/designee regarding; · following resident transfer status and location of information on care plan/Kardex in the electronic health record (POC) prior to transferring resident, including shower/bathing, ·Post falls follow up/procedures are completed as indicated per physician orders and or facility policy ·Checking shower chairs to ensure locks are working prior to transfer of resident. Shower	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hospital at 9:30 a.m., daughter at bedside. A late entry progress note, effective date 8/15/24 at 9:20 a.m., created 8/16/24 at 8:13 a.m., the DON documented resident lying in bed, complaint of pain to left (L) side, alert and oriented, head to toe assessment completed, no discoloration noted to body, no raised areas, per family resident complained of numbness to face, writer assessed no hardened or raised areas noted, skin normal to touch, resident able to feel writer touching face, no change in speech pattern, no change in mental status, family request resident be transferred to ER for evaluation and treatment related to fall previous day, positive range of motion (ROM) noted, no skin alterations noted, resident to be transferred to (a local hospital) per family request, no further concerns noted. A physician's order, dated 8/15/24, indicated transfer resident to (a local hospital) per family request for evaluation and treatment. A transfer form, dated 8/15/24, indicated discharge to hospital for pain. The resident ambulated only with human assistance. On 8/15/24 a new intervention was added to the care plan, dated 6/3/24, after the resident discharged to the hospital, indicating to use 2 staff at all times for transfers. A hospital emergency department visit note, dated 8/15/24 at 10:15 a.m., chief complaint was a fall from a standing position, leg pain, and chest pain. The note indicated the patient presented from a nursing home after a fall. Nursing staff reported to EMS that the patient lost her balance getting out of the shower and was helped to the ground. The patient reported she fell and struck		chairs with locks not working will be removed from the shower room and not used until repaired by maintenance personnel. ·Post fall documentation to include fall follow up, neuro checks if unwitnessed falls or resident was seen hitting head and or evidence head was hit ·The above education will be provided during orientation and as indicated, ongoing. ·Maintenance personnel will be provided with training by the maintenance supervisor and administrator regarding routine maintenance follow-up of shower chairs to ensure working conditions with wheel locks and documentation of checks. Maintenance personnel will remove shower chairs from use if locks are not working and communicate with the administrator. Shower chairs will be reported for maintenance and not used if malfunctioning and removed from the floor. ·Monitoring to ensure alleged deficient practice does not recur; In-house falls will be reviewed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the back of her head. Physical exam comments indicated the left pupil was sluggishly reactive, and the right pupil was nonreactive. Extensive bruising noted to right upper and lower leg. A hospital emergency department visit note, dated 8/15/24 at 11:15 a.m., indicated a resident presented to the hospital post fall and hit her head, and complained of pain to head, neck, and lower extremities. Assessment/Plan, the patient was recently admitted for fall that resulted in multiple lower extremity injuries requiring operative repair on 5/27/24. Obtained computed tomography (CT - noninvasive x-rays to creature detailed pictures of the body) imaging which demonstrated rib, transverse process, and sacral fractures. Also obtained CT angiography of the head and neck after the fall to evaluate for possible cerebral occlusion leading to the fall, but there were no acute findings on the studies. The patient was admitted to the trauma team for further management. CT radiology study of abdomen pelvis with contrast indicated: a. Slightly displaced left 10th and 11th rib fractures. b. Nondisplaced L3 right transverse process fracture (a break in the bony projection on the side of the third lumbar vertebra in the spine). c. Probable subacute left sacral (a mending fracture in the left side of the triangular bone at the base of the spine) and acute right sacral nondisplaced fractures (new breaks in the right side of the large triangular bone at the base of the spine), not visualized on recent comparison study 5/27/24. d. Healing subacute right superior and inferior rami fractures (fracture of the pelvic ring). An Interdisciplinary Team (IDT) note, dated 8/16/24 at 1:40 p.m., indicated IDT met to review		the DON/designee, IDT to ensure post fall follow up completed per facility guidelines 5x/week x90 days and recorded on audit. Results of observations and any actions taken will be discussed during the morning meeting with the IDT/QAPI team if further actions are required. ·transfer status observations will be conducted to ensure the res transfer plan of care being followed by the DON/designee, to include shower/bathing transfers and checking shower chair locks x5 residents weekly x4 weeks, then 3 res weekly x8 weeks. Results of observations and any actions taken will be discussed during the morning meeting with the IDT/QAPI team if further actions are required. ·Observations, on the secured memory care unit, for no unsecured cleaning chemicals within reach of residents will be conducted 5x/week x4 weeks, then 3x/week x4 weeks then weekly x4 weeks. Observations will be discussed with the IDT/QAPI and any actions taken during the morning meeting and if further actions are required. ol class="NumberListStyle1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	witnessed fall. The resident was noted to be lowered to the ground by a staff member while attempting to transfer from a shower chair to a WC. The resident's legs became weak, and she was lowered to the ground. She did not hit her head, positive ROM noted, no change in mental status, no visible injuries noted. Factors contributing to the fall: a wet floor, no non- skid footwear in place, and currently being treated for cellulitis of RLE. Diagnoses included muscle weakness, cognitive communication deficit, glaucoma, and falls. Root causes included weakness, unsteady weak gait, complaints of pain to RLE from cellulitis, shower chair malfunction with locking of wheels. New interventions included maintenance requested to fix shower chair brakes, and resident to be a two-person transfer. During an interview on 11/14/24 at 2:55 p.m., Registered Nurse (RN) 23 indicated the resident had been unable to transfer or ambulate on her own, she required 2 person assistance for safety. Review of the resident record with RN 23, dated 8/13/24 - 8/15/24, he indicated the resident record documentation did not reflect the resident had fallen on 8/14/24. The record lacked documentation on the day of the fall to include progress notes with description and root cause, the required fall risk and pain assessments, neurological assessments, or documentation the physician (MD) and resident representative were notified. There was no follow up documentation after the fall to indicate the resident's condition was being monitored. RN 23 indicated when a resident had a fall, the nurse should assess the resident for injury to include vital signs and start neurological checks if the fall was unwitnessed or if the resident had complaint of head injury. The nurse should have documented the fall, root		SCXW167392326 BCX8" role="list" start="6" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;" The facility administrator is responsible for the IDT/QAPI follow up as indicated above. The above plans will be updated as indicated through the QAPI committee. Date of compliance: 12.18.24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cause, and follow up in the progress notes, and as having notified the DON, family and MD. Documentation was required in the resident's record. During an interview on 11/15/24 at 10:30 a.m., the Administrator (ADM) indicated Licensed Practical Nurse (LPN) 9 had been in charge at the time of Resident D's fall on 8/14/24, her contact information was not available on the staff contact list. During an interview on 11/15/24 at 11:19 a.m., the resident record was reviewed with the ADM. The ADM indicated she did not see documentation in the record to reflect the resident had fallen on 8/14/24. During an interview on 11/15/24 at 11:38 a.m., the ADM indicated LPN 9 had been terminated the prior day related to issues including lack of documentation. During a confidential interview conducted during the survey, the interviewee indicated when viewing the resident record there was no documentation in the progress notes on 8/14/24 to reflect the resident had fallen, or a fall assessment had been completed. They had found a confidential internal document in risk management, dated 8/15/24 at 12:44 a.m., to indicate a fall on 8/14/24. The internal document lacked the name of the Certified Nursing Aide (CNA) involved with the fall, and date or time of the fall. Incident Description indicated resident eased down to the floor in shower room, she lost her balance, and CNA eased her to the floor. Resident assessed, no injury noted, ROM within normal limits, denied hitting head, resident put back in chair. Documentation on the internal form			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the MD was notified on 8/16/24 at 3:52 a.m., two days after the resident discharged to the hospital, and the Power of Attorney (POA) was notified 8/21/24 at 3:53 a.m., six days after the resident discharged to the hospital. The electronic medical record documentation indicated the resident had a shower on 8/14/24 at 10:37 p.m. The interviewee indicated CNA 18 had been the aide responsible for Resident D's shower on 8/14/24. An Employee Incident/Event Investigation Statement, dated 8/15/24, conducted by LPN 22 and signed by the DON, indicated on 8/14/24 (untimed) Resident D was being assisted out of shower chair to transfer to WC by CNA (unidentified). The resident became weak while standing and shower chair moved backwards while locked. The resident was lowered to the ground by CNA. The resident did not hit their head, no injuries noted. Resident assisted by 3 staff members off floor to WC. A Teammate Termination Notice, dated 11/14/14, indicated LPN 9 was terminated for failure to follow expectations regarding documentation/assessments as asked. Failure to follow expectations regarding documentation outlined in the job description: "Documents all pertinent information regarding nursing care, care plans, observation of the residents' overall condition and behavior ..." Employee refused to sign. During an interview on 11/15/24 at 12:32 p.m., the ADM had contacted the prior DON who indicated on the morning of 8/15/24, the daughter came in and referred to a fall the resident had the prior evening. The daughter indicated the resident was having hallucinations and face numbness. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	DON had investigated the allegation of a fall and found the resident had been given a shower by CNA 18, had slipped and been lowered to the floor. Neurological checks had not been initiated as Resident D had no head injury. The ADM indicated, on 8/15/24, the family called 911 to have the resident transferred to the hospital. During an interview on 11/15/24 at 12:50 p.m., CNA 18 indicated on 8/14/24 after dinner probably between 6:00 p.m. and 7:00 p.m., she had given Resident D a shower in the shower room located on the hallway. After the shower had been completed, she put lotion on the resident, put a shirt on her, pulled the resident's pants halfway up to her knees, and stood behind the resident as the resident stood up with the WC in front of her to hold onto. The resident's leg started to give out and as the resident leaned back against CNA 18. CNA 18 eased the resident down, sliding her on the CNA's clothes. CNA 18 indicated that the resident did not fall or hit her head. The CNA then opened the shower room door and yelled at LPN 9 to come to the shower room. LPN 9 assessed the resident, took vital signs, and asked about pain, which the resident denied. CNA 18 and another aide then placed the resident in her WC where she remained for another 90 minutes then was put to bed per her request. CNA 18 indicated, to her knowledge, the resident only required 1 person physical assistance for transfers, but she could not confirm this information. CNA 18 indicated that Resident D had been able to stand up with assistance, she had transferred the resident by herself without another staff member's assistance, and she was not aware of issues with the shower chair, so had not checked the shower chair prior to use when giving the resident a shower. Logs with documentation of preventative			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintenance, concerns with the functionality of shower equipment, or response in fixing the defective shower chair in response to the incident with Resident D were not provided during the survey process. During an interview on 11/22/24 at 11:06 a.m., LPN 9 indicated Resident D had been alert and oriented. LPN indicated she thought the resident required 1 or 2 person assistance for bed mobility, and she could not ambulate, just pivoted into her WC. The resident had been working with therapy, but she had never seen her walk. Indicated on 8/13/24 the resident had a big bruise on her leg, she had been to the hospital related to cellulitis. On 8/14/24 CNA 18 gave Resident D a shower, called LPN 9 to the shower room and indicated the resident had been pushing away from her, and she lowered the resident to the floor. The resident denied pain or injury, so was assisted into a WC by CNA 18 and CNA 25. The CNAs got her dressed, and she was left in her WC awhile before going to bed. LPN 9 indicated she had documented the fall in the nurse's notes, and completed a fall assessment, she was not sure why the documentation was not in the electronic medical record (EMR). On 11/13/24 at 12:00 p.m., the ADM provided a Fall Management Programming Healthcare policy, dated 11/14/23, and indicated the policy was the one currently being used by the facility. The policy indicated, definition of a fall, " ...the unintentional change in position coming to rest on the ground, floor or onto the next surface ...Post Fall: There are three key elements of the post-fall response and management. 1. Initial post fall evaluation. 2. Documentation and follow-up - including ongoing monitoring for resident changes in condition where medically indicated. 3.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Plan of care will be reviewed and updated as indicated ...Documentation and Follow-up: Following the post fall evaluation and any immediate measures to protect the resident ...a. Perform neuro-checks according to the organizational policy and guidelines. b. Immediately notify the attending physician and family or guardian of condition changes ...c. Transfer the resident for further evaluation and treatment where medically indicated. 2. Complete an incident report using Point Click Care (PCC - electronic documenting system) Risk Management Module ...4. A detailed progress note should be entered into the resident record including the results of the post-fall evaluation. 5. Refer the resident for further evaluation by physician to ensure other serious injuries have not occurred where medically indicated. 6. Implement 72 hour every shift post fall documentation. 7. Notification of fall and intervention(s) on 24-hour report for communication to oncoming shifts for purposes of 72 hour every shift follow up documentation ...Reporting and Notification: 1. Falls will be reported in the daily stand-up meeting and immediately following in the clinical meeting daily (M-F) ...." The policy did not address fall prevention related to two staff to perform transfers according the resident assessment. A policy related to preventative maintenance, and monitoring and checking the function of equipment was not provided during the survey process. This citation relates to Complaint IN00445487. B. A confidential interview was conducted during the survey and indicated Resident K, on the secured memory care unit, had supposedly swallowed a poisonous substance on 11/11/24.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident K's record was reviewed on 11/14/24 at 11:07 a.m. Resident K was admitted to the facility on 3/4/24 with diagnoses included, but not limited to, chronic obstructive pulmonary disease with acute exacerbation (a common lung disease that makes it difficult to breathe and worsens over time), dyspnea (the feeling of not being able to breathe fast enough or deeply enough), and dementia (a loss of cognitive functioning, such as thinking, remembering, and reasoning, that interferes with daily life). A quarterly Minimum Data Set (MDS) assessment, dated 9/11/24, indicated the resident had a severe cognitive impairment, required supervision or touching assistance for eating, oral hygiene, and dressing, was partial to moderate assistance for toileting hygiene, and was substantial to maximal assistance for personal hygiene and bathing. A care plan, initiated on 3/9/24 and revised on 6/17/24, indicated Resident K had impaired cognitive function/impaired thought processes, and resided on a locked memory care unit due to the diagnosis of dementia with the care plan interventions, all dated 3/9/24, to administer medication per physician orders and notify physician with any change in resident's condition; encourage/engage resident to participate in activities on the memory care unit; and monitor resident for safety when walking around the unit. A nurse's progress note, written by Licensed Practical Nurse (LPN) 16, dated 11/11/24 at 4:35 p.m., indicated Resident K drank Faboloso (multi-purpose cleaner) and poison control was contacted. The resident drank 240 milliliters (mL) of milk and ate a few graham crackers with no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	complaints of illness or sickness. The Faboloso cleaner label information indicated the following instructions: Keep out of reach of children; Do not swallow; If inhaled, move to fresh air; If swallowed, rinse mouth and drink 1-2 glasses of water; Contact a poison control center or doctor. The Material Safety Data Sheet (MSDS) for Faboloso indicated Faboloso cleaner was harmful if swallowed and do not drink milk or alcohol. Resident K's record lacked documentation of progress notes or other documentation to indicate the physician or resident's representative were notified of the resident ingesting a poisonous chemical. There was not a physician's order for follow up of signs or symptoms of the resident ingesting a poisonous chemical and no care plan was initiated for the resident ingesting a poisonous chemical. The record lacked progress notes or assessments related to the resident ingesting a poisonous chemical, no physician's or nurse practitioner's note to indicate they were made aware of the resident ingesting the chemical, and no orders for follow up. During a tour of the memory care unit, on 11/14/24 at 11:30 a.m., the memory care unit laundry room door was observed propped open and the unlocked laundry room cabinet contained an empty bottle of Faboloso Original Multi-Purpose Cleaner and ECOLAB Home-style solid laundry detergent with color safe bleach plastic wrapped brick in a box. On 11/14/24 at 11:58 a.m., Housekeeper 21 observed going in and out of Memory Care Unit residents' rooms and the shower room, pushing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	around a housekeeping cart with the cabinet that stored cleaning products unlocked. Housekeeper 21 was observed walking away from the housekeeping cart to go into the shower room. Housekeeper 21 indicated she had keys for the housekeeping cart, and it should have been locked, but the lock was broken. The cart contained the cleaning chemicals of a bleach urine remover spray bottle, a plastic bottle container of liquid hand soap, a container of stainless steel cleaner and polish, a 32-ounce (oz.) foaming acid cleaner spray bottle, a spray bottle of 32-oz. disinfecting acid bathroom cleaner, a spray bottle with 32-oz. of multi-surface peroxide, a spray bottle of 32-oz. glass force professional strength glass cleaner, a 32-oz. squeeze bottle of heavy duty toilet bowl cleaner, a 32-oz. bottle of micro-kill concentrated disinfectant cleaner, and a deodorizer spray bottle. She indicated she had not used the cleaning solution Faboloso in the facility. During an interview, on 11/14/24 at 12:19 p.m., Certified Nursing Aide (CNA) 15 indicated, on Monday, 11/11/24 at about 9:00 a.m., CNA 15 cleaned the dining room tables with Faboloso Cleaner and a cleaning towel. CNA 15 sat the Faboloso cleaner bottle on the countertop island by the tables in the dining room/activity area and then helped another staff member with two residents' showers in the shower room and forgot about the Faboloso cleaning bottle on the counter. She had gotten the bottle of Faboloso from the activity cabinet. CNA 15 indicated she had finished the residents' showers and went on with the rest of the day. On the evening shift, staff observed Resident K drinking the bottle of Faboloso and they told the memory care unit nurse. CNA 15 indicated she was not on the memory care unit at the time of the incident, she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had just heard about the incident. The Memory Care Director had texted CNA 15, on 11/12/24, and asked if she had left the bottle Faboloso cleaner out on the memory care unit common area counter. CNA 15 had texted back, that yes, she had left the cleaning solution out on the counter in the memory care unit. MC texted back that Resident K had drunk some of the cleaner and staff had contacted the Director of Nursing (DON) and poison control. Resident K was okay, but staff had to put stuff away. The residents do not know any better. CNA 15 texted back to MC that yes, she had left the cleaning solution bottle on the memory unit counter, and it was an honest mistake. She was just trying to hurry and clean the dining tables and forgot to put the cleaner back into the cabinet. CNA 15 indicated she had worked at the facility for about a year and six months and could not recall the facility training her about keeping chemicals away from the memory care unit residents. On 11/15/24 at 1:02 p.m., the Director of Environmental Services (EVS) indicated the facility did not have a policy for keeping chemicals away from the residents but had a staff training class outline that specified all chemical bottles should be properly labeled and stored in a locked cabinet. The facility had not purchased the cleaner. The facility did not stock Faboloso cleaner, the memory care unit staff must have brought the cleaner onto the memory care unit. The Administrator (ADM), on 11/15/24 at 12:34 p.m., indicated she did not know about the Faboloso cleaner incident with Resident K, on Monday 11/11/24, but found out about the incident in the morning meeting on Tuesday 11/12/24. One of the staff had observed Resident K holding a bottle of Faboloso cleaner and staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had called the Director of Nursing (DON) and poison control. ADM indicated, the Executive Director (ED) had told the ADM, since Resident K did not ingest the Faboloso chemical there was nothing to report to the Indiana Department of Health. The facility did not purchase the Faboloso cleaner. The staff had brought in the cleaner. CNA 20 observed Resident K with the Faboloso in her hand and heard Resident K indicate, "This thing smells like sh-t!" Staff had contacted the DON and reported that Resident K had the bottle of Faboloso in her hand and had yelled out "Yuck!" Staff had assessed the resident and looked into her mouth and there was not a smell of the cleaner in the mouth with the mucous membrane moist and normal color. No one saw Resident K drink the cleaner and the resident yelled out "Yuck." ADM indicated, on 11/11/24 at 4:12 p.m., the Nurse Practitioner (NP) was notified, and she ordered to call poison control. At 4:15 p.m., poison control indicated to give the resident milk and a snack and to monitor for any changes in condition or seizures. Resident K was sitting with staff and drinking fluids and having snacks. Staff removed Faboloso cleaner from the memory care unit. ADM indicated today, 11/15/24, ADM had ordered staff to do a complete search of the memory care unit for Faboloso, and staff had removed a bag of items out of the memory care unit. The ADM indicated the DON had written a statement and indicated the nurse on the memory care unit had her back turned and did not see the incident. ADM asked the Executive Director (ED) if the incident was a reportable and the ED had responded that staff did not observe the resident ingest the Faboloso cleaner, therefore it was not a reportable. If the incident was a poisoning, the facility would have sent the resident out to the hospital. ADM was unable to find documentation of the physician being notified of the incident nor			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessments of the resident for the incident. On 11/15/24 at 3:32 p.m., ADM provided written statements from CNA 20, the nurse, and the DON about the 11/11/24 incident. CNA 20's handwritten statement indicated, she was sitting with another resident when she heard Resident K say, "This thing smelled like sh-t!" and when CNA 20 turned around she saw Resident K holding the bottle of Faboloso cleaner. CNA 20 took the bottle from Resident K and told the nurse. Licensed Practical Nurse (LPN) 22's handwritten statement indicated, on 11/11/24 at 4:00 p.m., a call came to the healthcare unit to come to the memory care unit, because Resident K was observed with a bottle of Faboloso cleaner in her hand and yelled out, "Yuck!" Resident K was assessed and there was no smell of Faboloso cleaner in her mouth with the mucous membranes moist and a normal color with no noted changes in Resident K. No staff saw Resident K drink the cleaner. The Faboloso cleaner bottle was in the resident's hand and the resident yelled out, "Yuck!" At 4:12 p.m., the nurse notified the nurse practitioner of the incident and was advised to call poison control. At 4:15 p.m., the nurse contacted poison control who instructed the nurse to give Resident K water and milk with a snack and monitor for a change in level of consciousness or seizures. At 4:30 p.m., Resident K was observed sitting with staff, no noted changes and drinking fluids and having snacks. At 4:40 p.m., the Faboloso cleaner bottle was removed from the memory care unit and discarded into the trash. The DON's handwritten statement indicated she had received a notification that the nurse needed help on the memory care unit. When the DON arrived on the memory care unit, she observed LPN 22 and CNA 20 standing next to Resident K and LPN 22 had a Faboloso bottle in her hand. When the DON			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	asked what happened, CNA 20 had indicated she had heard Resident K say, "This smells like sh-t" and CNA 20 observed Resident K with the Faboloso cleaner bottle towards Resident K's face. CNA 20 took the bottle away from Resident K immediately and Resident K was assessed by the nurse and within normal limits with no odor on the resident's breath and no evidence of Faboloso observed on the resident's tongue. Resident K was in good spirits with no changes in level of consciousness. The Nurse Practitioner and resident's family were notified of the incident. Poison control was called, and instructions were followed. CNA 20 denied seeing Resident K drink the Faboloso cleaner. Precautions were taken and staff were educated about keeping chemicals out of reach of the residents. On 11/15/24 at 3:40 p.m., ADM provided documentation of the facility's internal incident documentation, dated 11/11/24 at 7:42 p.m., which indicated, incident description with nursing description of, Resident K was in the common area standing around and the nurse had not seen the resident drink Faboloso but the CNA had reported they saw Resident K drink a little of the Faboloso and the CNA quickly took the bottle away from Resident K. The nurse assessed the resident with no reactions or complaints of illness from the resident with the vitals within normal limits. Poison control was contacted, and the nurse was instructed to give the resident milk and a snack. Resident K drank 240 mL of milk and ate a few graham crackers. The physician, DON, and family were notified of the incident. An Interdisciplinary Team (IDT) progress note, written by the MC, dated 11/12/24 at 10:08 a.m., which indicated IDT reviewed the incident and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident K showed no adverse signs or reaction from the cleaning product. A nurse's focused charting follow-up note, dated 11/13/24 at 11:07 p.m., indicated Resident K remained on fall follow-up, resident ate in the dining room and socialized with other residents for some time this evening. Resident K seemed to be in good spirits with no signs or symptoms of pain or distress and neuros and vital signs were within normal limits. A nurse's focused charting follow-up note, dated 11/14/24 at 3:39 a.m., indicated Resident K was observed resting in bed with eyes closed, no signs or symptoms of pain or discomfort noted at this time from ingesting cleaning solution.On 11/15/24 at 12:00 p.m., the ADM provided an Acute Condition Changes policy, dated March 2018, and indicated the policy was the one currently being used by the facility. The policy indicated, "The physician will help to identify individuals with a significant risk for having acute changes of condition during their stay...8. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response..."Monitoring and Follow-up, 1. The staff will monitor and document the resident/patient's progress and responses to treatment...3. At the next visit, the physician			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	will review the status of the condition change and document his/her evaluation..."On 11/15/24 at 3:07 p.m., ADM provided and identified a document as a current facility policy, titled "Storage Areas, Environmental Services," dated December 2009. The policy indicated, " ...Policy Statement ...Housekeeping and laundry department storage areas shall be maintained in a clean and safe manner ...."3.1-45(a)(1) 3.1-45(a)(2)			