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F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Nursing Home Complaints IN00415162, IN00416020, IN00423142, IN00423200, IN00425546, and IN00425619. This visit included the Investigation of Residential Complaint IN00413196.

Complaint IN00415162 - No deficiencies related to the allegations are cited.

Complaint IN00416020 - No deficiencies related to the allegations are cited.

Complaint IN00423142 - No deficiencies related to the allegations are cited.

Complaint IN00423200 - No deficiencies related to the allegations are cited.

Complaint IN00425546 - Federal/State deficiencies related to the allegations are cited at F684.

Complaint IN00425619 - No deficiencies related to the allegations are cited.

Survey dates: January 22, 23, 24, 25, and 26, 2024

Facility number: 001156
Provider number: 155505
AIM number: 100453350

Census Bed Type:
SNF/NF: 51
Residential: 54
Total: 105

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 000	Continued From page 1 Census Payor Type: Medicare: 10 Medicaid: 28 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 1, 2024.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide necessary treatments and services to promote the healing of non-pressure ulcers for 1 of 3 residents reviewed for skin impairment (Resident E). The deficient practice was corrected on 1/3/24, prior to the start of the survey, and was therefore past noncompliance. Findings include: A confidential statement indicated, on 1/1/24 a resident advocate was in the facility to visit Resident E and smelled a foul odor around the	F 684	Past noncompliance: no plan of correction required.	

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resident. A dressing on the resident's foot was dated as last changed on 12/24/23, and it was supposed to have been changed daily. The dressing was stuck to the wounds on Resident E's foot, and a nurse had to soak the dressings to remove and change them. The resident was sent to a local hospital related to the wounds and was kept overnight.

On 1/23/24 at 10:59 a.m., Resident E was observed sitting in a bariatric wheelchair in his room watching television (TV) while feeding himself breakfast with a spoon that had a built-up handle. The resident was observed to be wearing blown up boots on his bilateral lower legs and feet, and his toes were covered in white gauze dressings. Resident E indicated his feet were healing well now that staff in the facility and at the wound center were both treating them.

Resident E's record was reviewed on 1/23/24 at 2:35 p.m. Diagnoses on Resident E's profile included, but were not limited to, peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and chronic pain.

Physician's orders related to wounds included, but were not limited to,
a. 10/5/23 right lateral ankle apply skin prep (forms a barrier between the patient's skin and adhesives to help preserve skin integrity) and Mepilex with boarder (foam dressing used to manage wound exudate fluid), change daily and as needed.
b. 12/1/23 sacral wound cleanse with normal saline (NS), apply calmoseptine ointment (barrier to protect skin from irritants/moisture) and cover with foam dressing, change daily and as needed.

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c. 12/1/23 right medial lower leg wound cleanse with NS, apply non-stick dressing and cover with foam dressing change daily and as needed.
d. 12/1/23 left lower leg wound cleanse with Dakins 0.25% solution (diluted bleach used to kill most forms of bacteria and viruses) apply Xeroform dressing (non-adherent dressing used to maintain a moist wound environment while promoting healing) cut to fit, cover with silver alginate (antibacterial dressing used for wounds with high exudate), ABD (abdominal gauze pads used for heavily draining wounds) and kerlix wrap (gauze roll used to hold dressings in place and absorb drainage), tape, change daily and as needed.
e. 12/22/23 left lateral foot cleanse with wound cleaner (saline based spray), apply Santyl ointment (debriding agent to remove damaged tissue), cover with ABD and kerlix, tape, change daily and as needed.
f. 12/22/23 left medial upper leg wound cleanse with wound cleanser, cover with silver alginate, ABD and kerlix, tubigrip (tubular compression stocking containing latex), change daily and as needed.
g. 12/22/23 left posterior upper leg wound cleanse with normal saline (NS), apply calmoseptine and cover with foam dressing, change daily and as needed.
h. 12/22/23 right heel pain with betadine solution (antiseptic used to prevent infection and promote healing in wounds), cover with 4 inch (in) x 4 in gauze, cupped ABD pad, secure with kerlix and tubigrip, change daily and as needed.

Medication Administration Record (MAR) dated December 23, 2023 - January 1, 2024, indicated documentation Registered Nurse (RN) 13 and Licensed Practical Nurse (LPN) 12 had signed as

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having provided treatment to Resident E's wounds per physician's orders.

A progress notes, dated 12/28/23 at 2:54 p.m., indicated family member visiting at the time, Resident E refused to be put in bed for wound pictures and assessment.

A progress notes, dated 1/1/24 at 6:00 p.m., indicated at 5:45 p.m. family member informed nurse that the resident needed his bandages changed. Nurse noted oozing purulent drainage and foul odor. Wounds cleaned and assessed with family at bed side. After cleaning wounds, the family instructed the nurse to call the physician and send the resident to the hospital.

A progress notes, dated 1/3/24 at 2:20 p.m., resident returned from the hospital and did not want to lay down for skin evaluation, agreed to do skin evaluation after laid down that evening, also requested treatments be done at night and not during the day.

A veteran's hospital report, dated 12/14/23, indicated all wounds resolved today. Did not need follow-up. Following orders were for protection and prevention:
a. Right heel: paint with betadine, cover with 4 x 4 and cupped abdominal pad, secure with kerlix and tubigrip G, change daily.
b. Bilateral lower extremity and foot ulcers: cleanse with wound cleanser and pat dry, apply skin prep to peri wound skin, apply Santyl a nickel thick to wound beds, cover with 4 x 4, cover with ABD pad, secure with kerlix and tubigrip G, change daily.
c. Left ischium: cleanse with wound cleanser and pat dry, apply silver alginate to wound bed, cover

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with 2 x 2 and secure with bordered foam, change daily.
d. Suprapubic tube entry site: cleanse with wound cleanser and pat dry, apply silver alginate, cover with split drain sponge and secure with tape, change daily.
e. Sacrum: cleanse with wound cleanser and pat dry, apply skin prep, apply sacral Mepilex, change daily.
f. Perineal: cleanse with wound cleanser and pat dry, apply thick layer of sensicare or equivalent cream, apply twice daily and as needed for incontinence episodes.
g. Please ensure that patient has his prevalon boots on at all times unless transferring.
h. Do not scrub off old zinc oxide, use wipes to cleanse outer layer and apply over the old zinc oxide to leave a base layer for protection.

A wound report from a contract wound care company, dated 1/4/24, indicated the resident had last been seen by the company on 9/2023 and resumed care on 1/4/24. The resident had wounds on bilateral lower extremities, context: venous and uncontrolled diabetes, modifying factors: PVD, and immobility. Associated signs and symptoms included, surrounding discolored tissue from PVD, no signs or symptoms of active infection. Resident E's family preferred if the resident was evaluated by the wound clinic at the veteran's hospital. Documentation of 8 wounds with description included,
a. Left lateral lower leg wound currently open, etiology of venous leg ulcer, measured 3 centimeters (cm) length (L) x 3 cm width (W) x 0.1 cm depth (D).
b. Left lateral malleolus leg wound currently open, etiology of venous leg ulcer, measured 4.5 cm L x 2.0 cm W x 0.1 cm D.

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c. Left lateral foot wound currently open, etiology of venous leg ulcer, measured 3.0 cm L x 4.5 cm W x 0.1 cm D.
d. Left medial foot wound currently open, etiology of venous left ulcer, measured 3.5 cm L x 0.5 cm W x 0.1 cm D.
e. Right medial lower leg wound currently open, etiology of venous leg ulcer, measured 3.8 cm L x 4.0 cm W x 0.2 cm D.
f. Right calcaneus wound currently open, etiology diabetic wound/ulcer, measured 2.0 cm L x 1.6 cm W x 0.1 cm D.
g. Right second toe wound currently open, etiology of diabetic wound/ulcer, measured 1.5 cm L x 0.5 cm W x 0.1 cm D.
h. Right plantar foot wound currently open, etiology of diabetic wound/ulcer, measured 4.5 cm L x 3.5 cm W x 0.1 cm D.

A wound report from a contract wound care company, dated 1/11/24, indicated the resident had last been seen by the company on 9/2023 and resumed care on 1/4/24. The resident had wounds on bilateral lower extremities, context: venous and uncontrolled diabetes, modifying factors: PVD, and immobility. Associated signs and symptoms included, surrounding discolored tissue from PVD, no signs or symptoms of active infection. Resident E's family preferred if the resident was evaluated by the wound clinic at the veteran's hospital. Documentation of 9 wounds with description after 1 week of treatment included,
a. Left lateral lower leg wound currently open, etiology of venous leg ulcer, measured 3 centimeters (cm) length (L) x 3 cm width (W) x 0.1 cm depth (D). Status of wound unchanged.
b. Left lateral malleolus leg wound currently open, etiology of venous leg ulcer, measured 3.0 cm L x

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2.0 cm W x 0.1 cm D. Status of wound improving.
c. Left lateral foot wound currently open, etiology of venous leg ulcer, measured 3.0 cm L x 5.0 cm W x 0.1 cm D. Status of wound worsening.
d. Left medial foot wound currently open, etiology of venous left ulcer, measured 3.5 cm L x 0.5 cm W x 0.1 cm D. Status of wound unchanged.
e. Right medial lower leg wound currently open, etiology of venous leg ulcer, measured 3.8 cm L x 4.0 cm W x 0.2 cm D. Status of wound unchanged.
f. Right calcaneus wound currently open, etiology diabetic wound/ulcer, measured 1.5 cm L x 1.6 cm W x 0.1 cm D. Status of wound improving.
g. Right second toe wound currently open, etiology of diabetic wound/ulcer, measured 1.1 cm L x 0.5 cm W x 0.1 cm D. Status of wound improving.
h. Right plantar foot wound currently open, etiology of diabetic wound/ulcer, measured 4.5 cm L x 3.5 cm W x 0.1 cm D. Status of wound unchanged.
i. Left knee wound currently open, etiology of trauma, measured 1.8 cm L x 1.7 cm W x 0.1 cm D.

A veteran's hospital report, dated 1/18/24, indicated all wounds resolved today. Did not need follow-up. Following orders were for protection and prevention:
a. Right heel: apply betadine moistened gauze, cover with 4 x 4 and cupped ABD pad, secure with kerlix and tubigrip G, change daily.
b. Right hallux wound: cleanse with wound cleanser and pat dry, apply skin prep to peri wound skin, apply Santyl a nickel thick to wound beds, cover with 4 x 4, cover with ABD pad, secure with kerlix and tubigrip G, change daily.
c. Bilateral lower extremities and left ankle

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wound: cleanse with wound cleanser and pat dry, apply skin prep to peri wound skin, apply silver nitrate, cover with 4 x 4, cover with ABD pad, apply dry 2 x 2 between all toes, cover toes with ABD pad, secure all with kerlix and tubigrip G, change daily.
d. Suprapubic tube entry site: cleanse with wound cleanser and pat dry, apply silver alginate, cover with split drain sponge and secure with tape, change daily.
e. Sacrum, bilateral buttocks and perianal: cleanse with wound cleanser and pat dry, apply thick layer of sensicare or equivalent cream, apply twice daily and as needed for incontinence episodes.
f. Please ensure that patient has his prevalon boots on at all times unless transferring.
g. Do not scrub off old zinc oxide, use wipes to cleanse outer layer and apply over the old zinc oxide to leave a base layer for protection.

The resident record lacked documentation the physician and responsible party were notified of resident refusals of wound care, veteran's hospital and contracted wound NP orders had been clarified versus contradicting, or that the care plan reflected current wound care intervention documentation.

A witness statement by Therapist 16 indicated, "on an unspecified date, I attempted to contact [Resident E] for a therapy encounter. Upon arrival, I observed heavy seepage from bilateral lower extremities which had soaked through both bandages/wraps. Out of concern for patient health and hygiene, I sought out nursing [RN 13] and reported my findings...."

A witness statement by LPN 12, dated 1/2/24,

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indicated on December 25 and 26, 2023,she was the only nurse on the floor responsible for wound care and charting. She believed she forgot to do his dressing and charted his wound treatments by mistake.

A witness statement by RN 13, dated 1/2/24, indicated on 12/2723 Therapist 16 had come to her with concerns of Resident E's legs weeping. She informed the therapist she was unfamiliar with the resident's treatments but would change his dressings. During report on 12/28/23, she was shown a paper from the veteran's hospital that stated, "all leg wounds are healed, continue to wrap." However, there were dressing directions that she'd highlighted and had question marks by each direction because the paper contradicted itself. RN 13 attempted to get pictures of Resident E's wounds, in which he asked could it be done later, because he wasn't ready to get in bed. This was documented. In the subsequent days, RN 13 attempted to get pictures/complete wound care treatments and was met with resistance.

A quarterly MDS (Minimum Data Set) assessment, completed on 12/19/23, indicated the resident had the ability to make himself understood and to understand others. A Brief Interview for Mental Status (BIMS) score 13/15 indicated cognitively intact. No signs or symptoms of delirium, behaviors, or rejection of care. Resident was at risk of developing pressure ulcers/injuries. No unhealed pressure ulcers, no venous or arterial ulcers, and no diabetic ulcers present. Resident did have other open lesion(s) on the foot. Resident receiving pressure ulcer/injury care, and application of nonsurgical dressings (with or without topical medications)

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other than to feet, applications of ointments/medications other than to feet, and application of dressings to feet (with or without topical medications).

A wound care plan, dated 6/30/23, indicated Resident E had potential impairment and actual skin breakdown to skin integrity related to protein malnutrition history, cardiovascular accident (CVA), anemia, decreased mobility, decreased bed mobility, and PVD. On 1/4/24 new open areas on the right lower extremity included open right calcaneus (heel), right medial lower leg, right second toe and right plantar foot (tissue connected the heel bone to the toes, right proximal anterior lower leg. On 1/4/23 new open areas to left lower extremity included left lower leg, left lateral malleolus (ankle), left lateral foot, left medial foot, and knee. The goal was for skin injury to the lower extremities to be healed by the next review date. Interventions included, but were not limited to, encourage resident to not sit up for long periods of time, bilateral heel boots on or float heels off mattress, and good nutrition. Interventions added 1/22/24 during the survey included, notify physician if resident had continuous refusals of treatments, turn, and reposition every 2 hours, resident preferred treatments during the night shift as he was laying down, monthly wound visits to the veteran's clinic, NP from contracted wound services to see the resident, and treat wounds per the veteran's clinic orders.

During an interview on 1/23/24 at 11:10 a.m., Qualified Medication Aide (QMA) 14 indicated the resident required total assistance with a mechanical lift for transfers, but once in his wheelchair could propel himself. The resident had

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wounds on both of his feet and his bottom, but she was not sure of the cause or if they were acquired in the facility.

During an interview on 1/24/24 at 10:26 a.m., the Director of Nursing (DON) indicated Resident E had been admitted to the facility with wounds several months ago. Over the course of his stay, the resident had the option to be seen weekly in the facility by a wound care vendor that was contracted by the facility, but this was not the preference of the resident and responsible party. The nurse practitioner (NP) from the wound company rounded with staff and saw residents every Thursday, but Resident E had been seen only a few times by the wound vendor due to the spouse starting and stopping care with them. Instead, Resident E went out to a veteran's hospital monthly for wound care per the responsible party's request to be seen for vascular and arterial wounds, and diabetic complications. There was documentation of the resident's wounds and treatment orders from both the veteran's hospital and the wound care provider, sometimes with different treatment orders and wound documentation not matching.

The DON indicated recently the schedule for treatment of Resident E's wounds had been changed to be done at night per his request because once the resident was up daily in his wheelchair he refused to lay back down and have the treatments done. The resident had been provided with a specialty bed due to his height, and he wore specialty air boots on both feet.

During an interview on 1/24/24 at 11:01 a.m., the DON indicated it had been reported to management that LPN 12 and RN 13 had not

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been completing dressing changes and wound treatments for Resident E in December 2023, according to the nurses mostly due to the resident's refusal to lay down during the day for treatments. Upon investigation the claim, management found out LPN 12 and RN 13 had been charting Resident E's treatment as having been done daily when it had not been done, and the nurses did not manage the situation and assure the resident had treatment done. Both nurses were immediately suspended, then subsequently terminated. The resident was sent out to the hospital to be checked out, he stayed overnight, and testing indicated he had no infection. The facility notified the medical director and completed an emergent quality assurance (QA) protocol on the situation to include a whole house skin sweep for every resident, no other residents were found to be affected, and continuing education for the staff.

During an interview on 1/25/24 at 2:25 p.m., the contracted wound NP indicated she came in every Thursday to assess residents with a current wound, worsening wounds, and any new resident with wounds.

During an interview on 1/26/24 at 9:41 a.m., RN 15 indicated the day shift floor nurses, usually the RN if available, completed daily wound treatments as ordered by the physician. Weekly wound rounds were completed by the wound RN and wound team on Thursday. Resident E preferred his wound treatments to be completed on the night shift. Completion of wound treatments was documented on the electronic medication administration record/treatment administration record (MAR/TAR) wherever it was listed.

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 _____	C 01/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 684	Continued From page 13 On 1/26/24 at 10:10 a.m., the DON provided a Wound Care policy, dated October 2010, and indicated the policy was the one currently being used by the facility. The policy indicated, "The purpose of this procedure is to provide guidelines for the care of wounds to promote wound healing ...The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data [i.e. wound bed color, size, drainage, etc.] obtained when inspecting the wound. 7 How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and reason[s] why. 10. The signature and title of the person recording the data ...Reporting 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with the facility policy and professional standards of practice ...." This deficient practice was corrected by 1/3/24 after the facility implemented a systemic plan that included the following actions: assessment of all residents for skin issues, audit and update of care sheets for residents, corrective action for the nurses to provide wound care, in-servicing education to staff related to providing proper skin care of a resident, updating plan of care to reflect current status regarding wound care, and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI).	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 14 This Federal tag relates to Complaint IN00425546. 3.1-37(a)	F 684		