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	08/23/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00441530 and IN00440176. This visit included a State Residential Licensure Survey. Complaint IN00441530 - No deficiencies related to the allegations are cited. Complaint IN00440176 - No deficiencies related to the allegations are cited. Survey dates: August 18, 19, 20, 21, 22, and 23, 2024. Facility number: 001156 Provider number: 155505 AIM number: 100453350 Census Bed Type: SNF/NF: 61 Residential: 27 Total: 88 Census Payor Type: Medicare: 15 Medicaid: 25 Other: 21 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 5, 2024.	F 0000	Plan of Correction: Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during our recent annual survey at Robin Run Village. The Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. We are requesting a Paper Compliance Review with the submission of these remedies.	
F 0637 SS=E	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Blevins	Administrator	09/13/2024

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	08/23/2024

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
Bldg. 00	Chg Based on record review and interview, the facility failed to initiate a Minimum Data Set (MDS) significant change assessment after a change in condition for 3 of 3 residents reviewed for hospice change in condition (Residents 14 and 49). Findings include: 1. On 8/20/24 at 1:35 p.m., Resident 14's record was reviewed. A physician order, dated 6/22/24, indicated for her to be admitted to a local hospice. Her Minimum Data Set (MDS) assessments were reviewed. A significant change was not completed after her admission to hospice. Her diagnoses included, but were not limited to, malignant neoplasm of the pancreas (cancer of the pancreas), Alzheimer's disease (brain disorder), and a history of breast cancer. Her hospice care plan, dated 5/8/24, indicated she was on hospice and would enjoy small group activities. Her cancer care plan, dated 6/24/24, indicated she had a terminal prognosis related to pancreatic cancer and was on hospice. 2. On 8/20/24 at 11:23 a.m., Resident 49's medical record was reviewed. He was a long-term care resident who resided on the secured memory care unit with a diagnoses which included, but was not limited to, dementia (a degenerative brain disease which includes memory loss and cognitive decline).	F 0637	F637 It is the intention of this facility to initiate a Minimum Data Set (MDS) significant change assessment within 14 days after a change in physical or mental condition. 1 Residents 14 and 49's most recent MDS was reviewed to ensure accuracy and modifications were completed if possible. Policy reviewed with MDS coordinator. 2 A review of all current residents receiving hospice services was reviewed for MDS accuracy. Corrections made as indicated. 3 Upon receiving the hospice admission agreement, IDT will review and discuss. MDS will initiate significant change within 14 days. Care plans to be updated as indicated. 4 Random audits of assessments will be completed 3 times weekly for 8 weeks. QAPI committee will determine if further actions are needed. Plan to be updated as indicated. 5 Alleged Compliance 9/16/24	09/16/2024

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	08/23/2024

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 physician's order for hospice care was initiated on 3/15/24. A nursing progress note, dated 3/15/24, at 11:40 a.m., indicated Resident 49 had been admitted to hospice. Upon review of his MDS assessments, no significant change assessment had been initiated. During an interview on 8/20/24 at 1:38 p.m., the MDS Coordinator indicated the facility followed the Resident Assessment Instrument (RAI) for comprehensive assessment scheduling and a Significant Change Assessment should be completed when a resident was admitted to Hospice. The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, indicated a significant change MDS was required to be performed when a terminally ill resident enrolls in a hospice program or changed hospice providers and remained a resident at the nursing home. The significant change MDS must be completed within 14 days from the effective date of the hospice election. A significant change MDS "must be performed regardless of whether an assessment was recently conducted on the resident."			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on record review, interview, and record review, the facility failed to appropriately code the Minimum Data Set (MDS) with accurate information for 3 of 5 residents reviewed (Resident 11, 1, and 211).	F 0641	F641 It is the intent of this facility to ensure that assessments accurately reflect the resident's status.	09/16/2024

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	08/23/2024

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
	Findings include: 1. On 8/18/24 at 12:59 p.m., a record review was conducted for Resident 11. She had the following diagnoses which included schizoaffective disorder, diabetes mellitus type 2 (high blood sugar), anxiety disorder, and chronic kidney disease. She had a level II completed on October 28, 2021 due to having schizoaffective disorder. Her MDS, dated 12/2/23, indicated she did not require a level II assessment. 2. On 8/20/24 at 11:01 a.m., a record review was conducted for Resident 1. She had the following diagnoses but not limited to paranoid schizophrenia, major depression, heart failure, insomnia, and unspecified dementia. She had a level II, completed on January 22, 2024, due to having paranoid schizophrenia. Her MDS, dated 3/6/24 indicated she did not require a level II assessment. 3. On 8/20/24 at 9:59 a.m., a record review was conducted for Resident 211. She had the following diagnoses which included, but was not limited to, hypertension, anxiety, diabetes mellitus (high blood sugar), and degenerative disease of the nervous system. She admitted to the facility with hospice services on 7/31/24. The Minimum Data Set (MDS), dated 8/6/24, did not indicate Resident 211 was receiving hospice services. Requested an interview with the MDS coordinator several times on 8/20/24, 8/21/24, 8/22/24, and		1 A record review of resident 1,11, and 211 was completed and modifications were completed as appropriate. 2 All residents could be affected by this deficiency. 3 The Social Services Director completed an audit of residents with level II. An audit of residents receiving hospice services was completed. The MDS form will be used to conduct resident assessments and MDS coordinator will be educated on accuracy of assessments. 4 Random audits of assessments will be completed 3 times weekly for 8 weeks. QAPI committee will determine if further actions are needed. Plan to be updated as indicated. 5 Alleged Compliance 9/16/24	

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	08/23/2024

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
	8/23/24 without success. A policy, dated March 2022, titled, "Resident Assessments," was provided by the Administrator (ADM) on 8/21/24 at 11:39 a.m. It indicated, "The interdisciplinary team uses the MDS form currently mandated by federal and state regulation to conduct the resident assessment ...."			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to implement a fall care plan for a resident with a history of falls for 1 of 5 residents reviewed (Resident 60). Findings include: On 8/20/24 at 10:37 a.m., a record review was conducted for Resident 60. He had the following diagnoses which included, but were not limited to, myocardial infarction (MI) (heart attack), hypertension, and vitamin D deficiency. He was admitted to the facility on 5/3/24 with a history of falls. His medical record lacked documentation of a care plan to address his risk for falls and interventions included to prevent falls from occurring. During an interview with the Director of Nursing (DON) on 8/23/24 at 10:28 a.m., she indicated she could not find the fall care plan and he was only at facility for a short time." A policy dated March 2022 titled, "Care Plans, Comprehensive Person-Centered" was provided by the Executive Director (ED) on 8/22/24 at 9:17	F 0656	F656 It is the intent of this facility to implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 1 The care plan for resident 60 was reviewed and revised. 2 All residents have the potential to be affected. 3 An audit of resident charts was conducted to ensure care plans are an accurate reflection of resident conditions. 4 Care plans will be developed by IDT upon admission and revised as appropriate. Care plans will be reviewed and updated quarterly and as needed. QAPI committee will determine if further actions are needed. Plan to be updated as indicated. 5 Alleged Compliance 9/16/24	09/16/2024

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	08/23/2024

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.m. It indicated, "The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident." 3.1-35(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, interview and record review, the facility failed to ensure a resident (Resident 43) received comprehensive assessments treatment and services to maintain or improve her nutritional status for 1 of 2 residents reviewed for nutritional services, and failed to administer formula through a resident's gastrostomy tube who was losing weight for 1 of 2 residents reviewed for nutritional services (Resident 53). Findings include: 1. On 8/19/24 at 9:56 a.m., Resident 43 was observed in her room on the secured memory care unit. She laid on top of her mattress at the edge of the bed, as to make room for three realistic baby dolls which were swaddled beside her. Her back was to the rolling over-bed table where her breakfast tray had been placed. The lid remained over the plate. Her silver wear remained wrapped up in a napkin, and her beverages and Magic Cup (a type of nutritional caloric supplement) was unopened. When her breakfast lid was lifted, her breakfast plate was observed undisturbed, and 0% of the meal had been consumed. Alternative food was not offered. On 8/19/24 at 2:42 p.m., Resident 43 was observed	F 0692	F692 It is the intent of this facility to ensure that all residents receive comprehensive assessment, treatment, and services to maintain or improve nutritional status. 1 Resident 43 has been reviewed by the interdisciplinary team to ensure supplements, set up and encouragement, alternatives, timely nutrition assessments, and documented weights are provided, and the care plan has been revised accordingly. Educated staff on notification of physician and/or dietician when any resident poses a nutrition risk. Resident 53 was given his formula, and his feeding tube was started. 3 hours were added to the run time due to the late start. A new assessment was completed, and interventions were added to the revised care plan. Tube feeding was changed to continual. 2 All residents have the potential to be affected. All	09/16/2024

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	08/23/2024

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
	as she attempted to pack up her personal belongings and indicated, 'she needed to get to school.' Resident 43's lunch tray was observed on her over-bed table. Her plate was covered, her silver wear was wrapped, and her beverages were unopened. Resident 43 waved her hand over the tray and made a disgusted face and shook her head "no." An alternative meal was not offered when her tray was removed. On 8/22/24 at 12:54 p.m., Resident 43 was observed in the main dining room area, seated at a table with several of her peers. Her lunch plate was in front of her and 0% of her meal had been consumed. During an interview on 8/22/24 at 1:03 p.m., the Memory Care Director, indicated, several of the residents did not eat their lunch, so she had requested an alternative which she was told was rice and fish. When asked if it was normal for Resident 43 not to eat, the Memory Care Director indicated, it was pretty normal that Resident 43 did not eat very much or anything at all. She was a very picky eater, and it was hard to tell what she liked as Resident 43 was more or less non-verbal and could not say what she liked or preferred. On 8/22/24 at 1:25 p.m., a Dietary Assistant brought a cart of several supplemental lunch meals into the secured memory care unit. The cart was a rolling activity cart which was uninsulated, and the lunch meals had been placed in uninsulated, clear plastic containers. By the time the alternative meal choice arrived on the unit, Resident 43 had become agitated and refused to come back to the dining room table. On 8/20/24 at 9:39 a.m., Resident 43's medical record was reviewed. She admitted as a long-term		residents will receive a comprehensive assessment that includes nutrition status upon admission. All new admissions will be reviewed the following day in the clinical meeting, added to the “at risk” resident list and reviewed weekly in the “at risk” meeting if appropriate, and reviewed quarterly thereafter. 3 A list of nutrition at risk residents will be provided to each unit with current interventions to be available at mealtime for heightened monitoring of changing needs and increased assistance with meals. 4 The QAPI committee audit tool will be completed weekly times 4 weeks, then bi-weekly times 4 weeks, then monthly times one month, and quarterly thereafter. QAPI Committee will determine if further action is needed at that time. 5. Alleged Compliance 9/16/24.	

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	08/23/2024

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
	care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, unspecified dementia (an irreversible, degenerative brain disease with memory loss, and an overall decline in cognitive function), malnutrition, and an iron deficiency. An admission nutritional assessment, dated 3/15/24, indicated Resident 43 was at risk for malnutrition. Her body mass index (BMI) was less than 22%, she usually left 25% of more uneaten of her meals and had altered nutritional related lab values. A mini nutritional assessment, dated 6/4/24, indicated Resident 43 remained at nutritional risk with a score of 9. Resident 43's upcoming/next due assessments were reviewed, and on 8/18/24 her next comprehensive nutritional assessment was 5 days overdue. Resident 43' comprehensive care plans were reviewed and lacked documentation of implementation of a nutritional care plan. A Physician's Admission Progress Note, dated 3/4/24, indicated, " ...She appears to have some difficulty expressing her wants and needs verbally. She is able to nod and gesture and attempts to communicate her wants and needs...moderate protein-calorie malnutrition-Resident with thin, frail body habitus. Continue mirtazapine [an antidepressant medication often used as an appetite stimulant]... will add order for mighty shakes with all meals. Encouraged liberalized regular diet with snacks as desired ...." A Physician's Progress note, dated 3/6/24,			

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	08/23/2024

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, " ...seen today to follow up on recent lab results. She is noted to have some mild hypercalcemia, which is consistent with prior lab values. She also has a slight decrease in hemoglobin and hematocrit ... she has a low BMI, with reported weight from prior facility of 88 lbs [pounds]. She has been noted to have somewhat poor intake ...." A Physician's Progress note, dated 4/24/24, indicated, " ...she continues to exhibit poor appetite. Her weight is stable within 2 pounds of admission weight. She is unable to verbalize comprehensibly and therefore does not contribute to today ...." A Physician's Progress note, dated 7/15/24, indicated, " ...continue mighty shakes with all meals will add magic cup to provide more calorie dense food options. Encouraged liberalized regular diet with snacks as desired. Resident with poor intake of meat and eggs ...." An admission physician's order indicated, "weight on admission, repeat weekly x [times] 3 weeks in the morning every 7 day(s) for 4 weeks." There was no admission weight for 3/4/24 Resident 43's weight log was reviewed. On 6/14/24 she weighed 90.5 lbs. On 7/9/24 she weighed 89.2 lbs. and on 8/22/24 she weighed 87.2 lbs. On 08/14/24 Resident 43 was sent out to the hospital for increased shortness of breath and returned on 8/16/24. Upon her re-admission, a physician's indicated, "weight on admission, repeat weekly x 3 weeks in the morning every 7 day(s) for 4 weeks." There was no re-admission weight on 8/17/24.			

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	08/23/2024

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
	Nursing progress notes, dated 3/29/24 at 10:46 a.m., it was indicated she ate " ...50% or less for 2 or more meals in the day. Resident has poor appetite, receives supplements as ordered ...." The note lacked documentation the physician or dietician was notified. Nursing progress notes, dated 6/26/24 at 9:32 a.m., indicated she " ...50% or less for 2 or more meals in the day. Resident has a poor appetite r/t dementia supplement given as ordered ...." The note lacked documentation the physician or dietician was notified. Nursing progress notes, dated 8/13/24 at 12:33 p.m., it was indicated she ate, " ...50% or less for 2 or more meals in the day. Resident provided snacks and supplemental drinks ...." The note lacked documentation the physician or dietician was notified. Nursing progress notes, dated 8/14/24 at 8:55 a.m., it was indicated she ate, " ...50% or less for 2 or more meals in the day. Resident offered supplemental drink ...." The note lacked documentation the physician or dietician was notified. Nursing progress notes, dated 8/18/24 at 1:13 p.m., it was indicated she ate, " ...50% or less for 2 or more meals in the day. Resident has a poor appetite supplement taken freely ...." The note lacked documentation the physician or dietician was notified. During an interview on 8/23/24 at 10:11 a.m., the Director of Nursing (DON) and Dietician were present. The Dietician indicated, Resident 43 was initially assessed by another Dietician who was on medical leave at the time of survey, therefore,			

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	08/23/2024

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
	she had not seen Resident 43 and or had been requested by the nursing staff to see her. It was her plan to visit Resident 43 that morning as she had recently returned from a hospital stay. The DON indicated Resident 43 admitted in March, but went out to the hospital for a while, and was a new admission. Upon review of the census timeline with the DON and Dietician, they indicated she had not been discharged for an extended period of time, and her nutritional assessment was overdue. The Dietician indicated Resident 43 was at nutritional risk, but her weight had remained stable within three pounds since her admission. The Dietician indicated, she was not aware and had not been notified of the resident's several documented instances that she ate 50% or less for 2 or more meals in a day, which would have triggered Resident 43 for an acute visit. The DON and Dietician indicated a comprehensive care plan should have been developed. On 8/20/24 at 2:30 p.m., the Executive Director (ED) provided a copy of current facility policy titled, "Care Plans, Comprehensive Person-Centered," revised 3/2022. The policy indicated, "A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed an implemented for each resident ... the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status). And no more than 21 days after admission ...." On 8/21/24 at 1:45 p.m., the ED provided a copy of current facility policy titled "Food and Nutrition Services," revised 10/2017. The policy indicated,			

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	08/23/2024

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
	"Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident ... the multidisciplinary staff, including nursing staff, the attending physician and the dietician will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect waiting and nutritional intake and utilizations. A resident-centered diet and nutrition plan will be based on this assessment ... nursing personnel, with the assistance of the food and nutrition services staff, will evaluate (an document as indicated) food and fluid intake of residents with, or at risk for, significant nutritional problems. Variations from usual eating or intake patterns will be recorded in the resident's medical record and brought to the attention of the nurse. I nurse will evaluate the significance of each information and report it, as indicated, to the attending physician or dietician ...."2. On 8/18/24 at 11:54 a.m., a record review was conducted for Resident 53. He had the following diagnoses which included but were not limited to cerebral infarction (CI) (stroke), anemia, dysphagia (difficulty swallowing) and muscle weakness. Resident 53's April 2024 weight was 150.0 pounds. His weight on 8/16/24 was 133.4 pounds. He had a weight loss of 16.6 pounds over a 4-month period. This was a significant weight loss at 11.07%. Resident 53's record indicated he was unable to have oral nutrition related to dysphagia. He had an order, dated 7/25/24, for Osmolite 1.2 cal oral liquid give 75 ml (milliliter)/hr (hour) via g-tube (gastrostomy) every shift for continuous feeding, flush 30 ml every hour, turn off from 2:00 p.m. until			

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	08/23/2024

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
	6:00 p.m. Resident 53 had a care plan, dated 5/29/24, that indicated he was nothing by mouth (NPO) due to dysphagia from CVA (stroke). He was at risk for aspiration. The goal, dated 5/29/24, indicated Resident 53 would receive nutrition and fluids through g-tube (gastrostomy). A nutrition/dietary note, dated 8/14/24 at 2:58 p.m., indicated Resident 53 required tube feeding as means of nutrition due to dysphagia. Current weight was 132.4 pounds and held for 30 days. BMI (body mass index) was acceptable although resident had a thin appearance. Plan was to continue current enteral feeding plan and continue to monitor. During an observation was made on 8/21/24 at 8:53 p.m. His feeding pump was disconnected from his feeding tube. His formula was supposed to be infusing at 75 ml per hour per feeding tube. During an observation was made on 8/21/24 9:00 p.m., LPN 13 went into resident's room with a bag of formula and started his feeding tube. This was 3 hours late per order. During an interview with the Assistant Director of Nursing (ADON) on 8/19/24 at 1:49 p.m., she indicated she did not know why Resident 53 was losing weight. During an interview with the Registered Dietician (RD) on 8/23/24 at 10:17 a.m., she indicated she was aware of Resident 53's pump being turned off when it was supposed to be on. She added 3 additional hours to make up for the loss. She indicated she had not made any changes to his feeding because he was gaining weight (1 pound)			

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	08/23/2024

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
	and there have been no negative outcomes related to the observation. A policy titled, "Weight Assessment and Intervention," dated March 2022, was provided by the Executive Director (ED), on 8/22/24 at 9:16 a.m. It indicated, "...The threshold for significant unplanned and undesired weight loss... 6 months-10% weight loss is significant; greater than 10% is severe ...." On 8/21/24 at 2:25 p.m., the ED provided a copy of current facility policy titled, "Weight Assessment and Intervention," revised 3/2022. The policy indicated, "Resident's weights are monitored for undesirable or unintended weight loss or gain. Resident are weighed upon admission and at intervals established by the interdisciplinary team ... the physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example: cognitive or functional decline ... environmental factors ... increased need for calories and/or protein ... care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietician, the consultant pharmacist, and the resident or residents legal surrogate. Individualized care plan shall address to the extent possible: the identifiable causes of weight loss, goals and benchmarks for improvement and time frames and parameters for monitoring and reassessment ...." 3.1-46			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility	F 0755	F755	09/16/2024

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	08/23/2024

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
	failed to reconcile medications upon discharge for 2 of 5 residents reviewed for medication disposition (Residents 60 and 58). Findings include: 1. On 8/20/24 at 10:37 a.m., a record review was conducted for Resident 60. He had the following diagnoses which included but were not limited to myocardial infarction (MI) (heart attack), falls, hypertension, type 2 diabetes mellitus (high blood sugar), and vitamin D deficiency. Resident 60 discharged to home on 5/20/24. There was no record of the following medications reconciled at the time of discharge. a. Asprin (ASA) 81mg (milligrams) by mouth daily b. Atorvastion (used for high cholesterol) 40 mg by mouth daily c. Crestor (used for high cholesterol) 20 mg by mouth daily d. Dorzolamide HCL Timolol Mal Ophthalmic Solution 2-0.5% both eyes daily e. Eliquis (blood thinner) 20 mg by mouth daily f. Plavix (blood thinner) 75 mg by mouth daily g. Metoprolol tartrate (blood pressure) 25 mg by mouth two times daily h. Gabapentin (nerve pain) 100 mg 2 capsules by mouth three times daily i. Cephelexin (antibiotic) 250 mg by mouth four times daily j. Acetaminophen (pain) 325 mg 2 tablets by mouth every 4 hours/as needed k. Melatonin (sleep aide) 3 mg 2 tablets by mouth every 24 hours/as needed l. Ondansetron (nausea and vomiting) 4 mg by mouth every 8 hours/as needed 2. On 8/2 0/24 at 10:51 a.m., a record review was		It is the intention of this facility to reconcile medications upon discharge. 1 Nursing staff were educated on appropriate methods of reconciliation of medications upon discharge. 2 All residents discharged from this facility could be affected. 3 A chart review of the last 10 discharged residents was conducted. Verification of medication reconciliation was conducted as well. Education provided to licensed nursing staff as needed. 4 Chart audits will be conducted the next business day following a discharge during clinical meeting. Licensed nursing staff will be provided education during orientation and will be ongoing. QAPI committee will determine if further action is needed. Plan to be updated as needed. 5 Alleged Compliance 9/16/24	

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	08/23/2024

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
	conducted for Resident 58. She had the following diagnoses which included but were not limited to presence of artificial hip, age-related physical debility, chronic kidney disease, and age-related osteoporosis (bone disease). Resident 58 passed away on 6/6/24. There was no record of the following medications reconciled at the time of discharge. a. Aspirin (ASA) 81mg by mouth daily b. Miralax (stool softener 17 grams by mouth daily c. Paroxetine sodium (antidepressant) by mouth daily d. Bisacodyl suppository 10mg per rectum every 24 hours/as needed e. Morphine sulfate (pain) 20mg/ml (milliliters) 0.25mg every 4 hours/as needed On 8/23/24 at 10:28 a.m. during an interview with the Director of Nursing (DON), she indicated she provided all she could find for both resident's discharge medications. A policy titled, "Discharge Medications," was provided by the Executive Director (ED) on 8/22/24 at 9:16 a.m. It indicated, "The nurse shall complete the medication disposition record, including ... i. the signatures of the person receiving the medications and the nurse releasing the medications ... The nursing staff shall forward completed drug disposition records to medical records. The complete list of the resident's medications shall also be provided to the resident upon discharge ...." 3.1-25(a) 3.1-25(b) 3.1-25(1) 3.1-25(c)			

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	08/23/2024

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 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, record review, and interview, the facility failed to label tuberculin serum appropriately for 1 of 1 medication room reviewed. Findings include: On 8/19/24 at 10:17 a.m., the north nurse's station was observed in the presence of the Assistant Director of Nursing (ADON). Observed a vial of tuberculin serum that lacked a date to indicate when it was opened. During an interview with the Director of Nursing (DON) on 8/22/24 at 10:30 a.m., she indicated tuberculin serum needed to be dated when it was opened and in the refrigerator when not in use. A policy dated April 2019, was provided by the Executive Director (ED) on 8/21/24 at 11:37 a.m. It indicated, "Labels for stock medications include all necessary information, such as: the name and strength of the drug, the lot or control number, the expiration date when applicable, appropriate accessory and cautionary statements and directions for use..." 3.1-25(j) 3.1-25(m) 3.1-25(n)	F 0761	F761 It is the intent of this facility to ensure that all drugs and biologicals used in the facility be labeled in accordance with currently accepted professional principles, and include the appropriate accessor and cautionary instructions, and the expiration date when applicable. 1 The tuberculin serum that was not labeled was disposed of. 2 Any resident receiving a TB test could be affected. 3 All med rooms were audited to ensure all drugs and biologicals are labeled and dated. Staff re-educated and education will be provided during orientation and will be ongoing. 4 Audits of med rooms will be completed 2 times a week times 4 weeks, weekly times 4 weeks, then bi-weekly for 4 weeks, monthly times one month, and quarterly thereafter. QA committee will review results to determine if further auditing should occur. Plan to be updated as indicated. 5 Alleged Compliance 9/16/24	09/16/2024
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record	F 0812	F812	09/16/2024

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	08/23/2024

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
	review, the facility failed to ensure the food in the kitchens were dated according to policy for 1 of 1 observation and the refrigerator and freezer temperature logs were completed for 2 of 3 kitchen and pantry observations. Findings include: 1. On 8/18/24 at 9:55 a.m., during a tour of the main kitchen with the Dietary Manager (DM) and Chef 12. At 10:04 a.m., the walk-in refrigerator had 3 large bags of fresh thyme, one bag of fresh cilantro, one bag of fresh mint, one bag of fresh dill with no date of arrival or expiration. A large bag of pepperoni was observed not sealed, the expiration date was 8/9/24. A plastic bag of whipped cream was not dated. The feta cheese had no expiration date. At 10:10 a.m., the walk-in freezer had undated items; a plastic bag of crumbled sausage, package of impossible burgers, and a lemon meringue pie. 2. On 8/18/24 at 9:45 a.m., during a tour of the satellite kitchenette with the Dietary Manager (DM) the August refrigerator temperature log-in document was observed incomplete. a. No temperatures were logged for opening or closing for 8/1/24 to 8/5/24, 8/7/24, 8/8/24, 8/16/24, and 8/17/24. b. No opening temperatures were recorded for 8/14/24 to 8/18/24. c. No closing temperatures were logged on 8/6/24, 8/9/24 to 8/13/24, 8/16/24, and 8/17/24. On 8/18/24 from 9:55 a.m. to 10:30 a.m., during a tour of the main kitchen with the DM and Chef 10 the August refrigerators and freezer temperature		It is the intent of this facility that food to be stored at proper temperatures, and labeled, dated and sealed correctly. 1 All undated or unsealed items were disposed of. Monthly temperature logs were placed on refrigerators, freezers, and food lines. Daily temperatures are being entered into logs. Staff re-educated on labeling, dating and sealing food as well as completing all temp logs daily. 2 All residents who eat food on campus have the potential to be affected. 3 The dietary manager conducted an in-service including proper food storage, labeling, dating, sealing, and completion of all temp logs. Education will be provided during orientation and will be ongoing. 4 Monitoring will be completed 3 times a week for 12 weeks, 2 times a week for 8 weeks, and weekly for 4 weeks. QA committee will review results and determine if further action is required. Plan to be updated as indicated. 5 Alleged Compliance 9/16/24.	

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	08/23/2024

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
	log-in documents were observed incomplete. Reach-In Cooler: a. No temperatures were logged for opening or closing for 8/5/25 to 8/8/24, 8/16/24, and 8/17/24. b. No opening temperatures were recorded for 8/3/24, 8/4/24, 8/16/24, to 8/28/24. c. No closing temperatures were logged on 8/11/24 to 8/13/24 Cook Line: d. No temperatures were logged for opening or closing for 8/15/24 to 8/17/24. e. No opening temperatures were recorded for 8/18/24. f. No closing temperatures were logged on 8/14/24. Server Station Low Reach-In Cooler: g. No temperatures were logged for opening or closing for 8/15/24 to 8/17/24. h. No opening temperatures were recorded for 8/18/24. i. No closing temperatures were logged on 8/13/24 and 8/14/24. On 8/18/24 at 12:07 p.m., during a tour of the Memory Care (MC) pantry with Registered Nurse (RN) 10 the August refrigerator temperature log-in document was observed incomplete. a. No temperatures were logged from 8/12/24 to 8/18/24. A policy, titled, "Food Receiving and Storage," dated October 2017, was provided by the Administrator (Admin), on 8/19/24 at 2:58 p.m. A review of the policy indicated, " ...All foods stored in the refrigerator or freezer will be covered, labeled and dated ...."			

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	08/23/2024

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 policy, titled, "Refrigerators and Freezers," dated December 2014, was provided by the Admin, on 8/19/24 at 2:58 p.m. A review of the policy indicated, " ...Monthly tracking sheets for all refrigerator and freezers will be posted to record temperatures ...Monthly tracking sheets will include time, temperature, initials ...." 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interviews, the facility failed to document resident's blood sugars and insulin administration on the Medication Administration Record (MAR) for 2 of 5 residents reviewed (Resident 20 and 11). Findings include: 1. A record review was conducted for Resident 20. He had the following diagnoses which included but were not limited to hypertension, type 2 diabetes mellitus (high blood sugar), unspecified dementia, and chronic kidney disease. His MAR included an order, dated 7/3/24, which indicated Humalog KwikPen subcutaneous (SC) (under the skin) pen injector 100 unit/ml (milliliter) (insulin lispro) inject as sliding scale if blood sugar was 150-200 give 2 units of insulin, 201-250 give 4 units of insulin, 251-300 give 6 units of insulin, 301-350 give 8 units of insulin and if blood sugar is 351 or higher call provider, SC before meals and at bedtime for diabetes type 2. On the following dates and times his insulin documentation was omitted.	F 0842	F842 It is the intention of this facility to ensure that resident's blood sugars and insulin administration is documented on the Medication Administration Record (MAR) 1 Residents 20 and 11 were monitored to ensure no adverse effects. 2 All diabetic residents could be affected by this deficient practice. 3 All licensed nurses have been educated on documentation of blood sugars and insulin administration on the Medical Administration Record (MAR). 4 The Director of Nursing/Designee will review MAR for accuracy of diabetic residents daily in clinical meeting. Noncompliance of documentation will be met with progressive disciplinary action. 5 Alleged compliance date of 9/16/24	09/16/2024

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	08/23/2024

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. 8/6/24 at 6:30 a.m. b. 8/11/24 at 6:30 a.m. c. 8/12/24 at 6:30 a.m. d. 8/9/24 at 11:30 a.m. e. 8/3/24 at 4:30 p.m. f. 8/6/24 at 4:30 p.m. g. 8/7/24 at 4:30 p.m. h. 8/8/24 at 4:30 p.m. i. 8/9/24 at 4:40 p.m. j. 8/12/24 at 4:30 p.m. k. 8/14/24 at 4:30 p.m. l. 8/15/24 at 4:30 p.m. m. 8/3/24 at 9:00 p.m. n. 8/6/24 at 9:00 p.m. o. 8/7/24 at 9:00 p.m. p. 8/8/24 at 9:00 p.m. q. 8/9/24 at 9:00 p.m. r. 8/12/24 at 9:00 p.m. s. 8/14/24 at 9:00 p.m. t. 8/15/24 at 9:00 p.m. Resident 20 had a care plan, dated 7/1/24, that indicated he had diabetes mellitus. A goal included he would be free of signs and symptoms of hyperglycemia (high blood sugar). An intervention included to administer diabetes medication as order by physician and monitor/document for side effects and effectiveness. 2. A record review was conducted for Resident 11 on 8/20/24 at 1:21 p.m. She had the following diagnoses which included but was not limited to schizoaffective disorder, muscle weakness, type 2 diabetes mellitus, and difficulty walking. Her MAR included orders, dated 7/30/24, for Basaglar KwikPen insulin 100 unit/ml solution pen-injector, inject 34 units SC in the morning for diabetes, hold for blood sugar of 70 or less 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	08/23/2024

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
	notify the Medical Doctor (MD). The following doses of the medication were not documented on the MAR on the following dates. a. 8/6/24 at 5:00 p.m. b. 8/7/24 at 5:00 p.m. c. 8/8/24 at 5:00 p.m. d. 8/9/24 at 12:00 p.m. and 5:00 p.m. e. 8/12/24 at 5:00 p.m. f. 8/14/24 at 5:00 p.m. g. 8/15/24 at 5:00 p.m. She had an order, dated 5/9/24, for Flasp Flex Touch 100unit/ml solution pen-injector 17 units SC with meals for diabetes management. The following doses of the medication were omitted on the MAR. a. 8/6/24/ at 5:00 p.m. b. 8/7/24 at 5:00 p.m. c. 8/9/24 at 11:30 a.m. d. 8/10/24 at 6:30 a.m. e. 8/12/24 at 6:30 a.m. She had an order, dated 11/19/23, for blood sugars call MD if blood sugar was greater than 350 before meals and at bedtime for diabetes mellitus. Her blood sugar was omitted on the following dates. a. 8/6/24 at 6:30 a.m. b. 8/9/24 at 11:30 a.m. c. 8/10/24 at 6:30 a.m. d. 8/12/24 at 6:30 a.m. Resident 11 had a care plan, dated 10/29/21, that indicated she had diabetes mellitus and a goal that she would have no complications related to diabetes. An intervention included to administer diabetes medication as ordered by the doctor. Monitor/document for side effects 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	08/23/2024

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
	effectiveness. On 8/23/24 at 10:31 a.m., an interview was conducted with the Director of Nursing (DON). She indicated she talked to the staff involved with the omissions. They told her they gave the medication, and they forgot to go back and document that it was administered. She provided education to her staff. A policy titled, "Documentation of Medication Administration," was provided by the Administrator (ADM) on 8/21/24 at 11:34 p.m. It indicated, " ...Administration of medication must be documented immediately after (never before) it is given ...." 3.1-3(o) 3.1-24(r)			
F 9999 Bldg. 00	3.1-18 INFECTION CONTROL PROGRAM (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) The baseline tuberculin skin testing should employ the two-step method. For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after	F 9999	F9999 It is the intent of this facility to ensure that residents receive tuberculous (TB) screenings according to policy. 1 TB screenings were completed on resident 4,7,14,35,36,113,115, and 221. 2 This deficient practice could affect all residents at this facility. 3 An audit of TB screenings was conducted, and TB questionnaires were completed on all residents. 4 TB tests will be completed upon admission. Infection Prevention nurse will maintain a	09/16/2024

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	08/23/2024

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 first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure residents received tuberculous (TB) screenings according to policy for 8 of 9 residents reviewed for TB screenings (Residents 4, 7, 14, 35, 36, 113, 115, and 221) Findings include: On 8/20/24 at 10:05 a.m., several resident's records were reviewed for TB screenings. 1. Resident 14 was admitted on 2/16/24. Her record lacked documentation of TB screenings. 2. Resident 115 was admitted on 8/13/24. Her record lacked documentation of TB screenings. 3. Resident 36 was admitted on 7/2/24. He received a first step TB screening on 7/9/24. He lacked documentation of a second step. 4. Resident 35 was admitted 7/8/24. She received a first step TB screening on 7/9/24. She lacked documentation of a second step. 5. Resident 7 was admitted on 5/31/24. She had a first step TB screening on 6/1/24, the results were still pending. She lacked documentation of a second step. 6. Resident 113 was admitted on 8/6/24 and discharged on 8/19/24. His record lacked documentation of TB screenings. During an interview, on 8/21/24 at 11:49 a.m., the Director of Nursing (DON) indicated the admitting		log documenting 1st and 2nd step TB tests. Licensed nurses were educated on TB screening policy. Noncompliance will result in progressive disciplinary action. Admission records will be reviewed in the clinical meeting the following day after admission. The QA committee will determine if further action is needed. Plan to be updated as indicated. 5 Alleged compliance date of 9/16/2024.	

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	08/23/2024

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
	residents should have a complete assessment and a first and second step TB screening. During an interview, on 8/22/24 at 10:57 a.m., the Infection Preventionist (IP) indicated, about a month ago, she did an audit of missing TB screenings throughout the building and called her corporate resource. She did TB assessment questionnaires. 7. On 8/20/24 at 9:59 a.m., a record review was conducted for Resident 211. Her diagnoses included, but were not limited to, hypertension, anxiety, diabetes mellitus (high blood sugar), and degenerative disease of the nervous system Resident 211's record lacked documentation of second step PPD. When the facility became aware of this, it was administered. 8. On 8/19/24 at 11:40 a.m., a record review was conducted for Resident 4. She had the following diagnoses which included but were not limited to hypertension, major depression, and dementia. Resident 4's record lacked documentation of a first and second step PPD. During an interview, on 8/22/23 at the 9:53 a.m., the Director of Nursing (ADON) indicated that she went through and completed a TB risk questionnaire on all residents and had a QA (quality assurance) form that she was using to track PPDs. She indicated she had only been in the position for a short time.			

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	08/23/2024

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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00441530 and IN00440176. Complaint IN00441530 - No deficiencies related to the allegations are cited. Complaint IN00440176 - No deficiencies related to the allegations are cited. Survey dates: August 22 and 23, 2024. Facility number: 001156 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 5, 2024.	R 0000	Plan of Correction: Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during our recent annual survey at Robin Run Village. The Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. We are requesting a Paper Compliance Review with the submission of these remedies.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure the food in the kitchens were dated according to policy for 1 of 1 observation and the refrigerator and freezer temperature logs were completed for 1 of 1 kitchen observations. Findings include: 1. On 8/18/24 at 9:55 a.m., during a tour of the main kitchen with the Dietary Manager (DM) and Chef	R 0273	R273 It is the intent of this facility that food to be stored at proper temperatures, and labeled, dated and sealed correctly. 1 All undated or unsealed items were disposed of. Monthly temperature logs were placed on refrigerators, freezers, and food lines. Daily temperatures are being entered into logs. Staff	09/16/2024

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	08/23/2024

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
	12. Chef 12 indicated the facility was working to control the rodents. He indicated he had not personally seen any rodents. At 10:04 a.m., the walk-in refrigerator had 3 large bags of fresh thyme, one bag of fresh cilantro, one bag of fresh mint, one bag of fresh dill with no date of arrival or expiration. A large bag of pepperoni was observed not sealed, the expiration date was 8/9/24. A plastic bag of whipped cream was not dated. The feta cheese had no expiration date. At 10:10 a.m., the walk-in freezer had undated items, a plastic bag of crumbled sausage, package of impossible burgers, and a lemon meringue pie. 2. On 8/18/24 from 9:55 a.m. to 10:30 a.m., during a tour of the main kitchen with the DM and Chef 10 the August refrigerators and freezer temperature log-in documents were observed incomplete. Reach-In Cooler: a. No temperatures were logged for opening or closing for 8/5/25 to 8/8/24, 8/16/24, and 8/17/24. b. No opening temperatures were recorded for 8/3/24, 8/4/24, 8/16/24, to 8/28/24. c. No closing temperatures were logged on 8/11/24 to 8/13/24 Cook Line: d. No temperatures were logged for opening or closing for 8/15/24 to 8/17/24. e. No opening temperatures were recorded for 8/18/24. f. No closing temperatures were logged on 8/14/24. Server Station Low Reach-In Cooler: g. No temperatures were logged for opening or closing for 8/15/24 to 8/17/24. h. No opening temperatures were recorded for 8/18/24.		re-educated on labeling, dating and sealing food as well as completing all temp logs daily. 2 All residents who eat food on campus have the potential to be affected. 3 The dietary manager conducted an in-service including proper food storage, labeling, dating, sealing, and completion of all temp logs. Education will be provided during orientation and will be ongoing. 4 Monitoring will be completed 3 times a week for 12 weeks, 2 times a week for 8 weeks, and weekly for 4 weeks. QA committee will review results and determine if further action is required. Plan to be updated as indicated. 5 Alleged Compliance 9/16/24	

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	08/23/2024

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
	i. No closing temperatures were logged on 8/13/24 and 8/14/24. A policy, titled, "Food Receiving and Storage," dated October 2017, was provided by the Administrator (Admin), on 8/19/24 at 2:58 p.m. A review of the policy indicated, " ...All foods stored in the refrigerator or freezer will be covered, labeled and dated ...." A policy, titled, "Refrigerators and Freezers," dated December 2014, was provided by the Admin, on 8/19/24 at 2:58 p.m. A review of the policy indicated, " ...Monthly tracking sheets for all refrigerator and freezers will be posted to record temperatures ...Monthly tracking sheets will include time, temperature, initials ...."			
R 0305 Bldg. 00	410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance Based on observation, record review, and interview, the facility failed to remove expired tuberculin serum from the refrigerator for 1 of 1 medication room reviewed. Findings include: On 8/22/24 at 11:30 a.m., the assisted living facility refrigerator was observed in the presence of the Assisted Living (AL) Director. Observed a vial of tuberculin serum that had a date of 7/19/24 on the vial. During an interview with the AL Director on 8/22/24 at 11:35 a.m. she indicated she did not realize the serum was expired. A policy, dated April 2019, was provided by the Executive Director (ED) on 8/21/24 at 11:37 a.m. It	R 0305	R305 It is the intent of this facility to ensure that all drugs and biologicals used in the facility be labeled in accordance with currently accepted professional principles, and include the appropriate accessor and cautionary instructions, and the expiration date when applicable. 1 The tuberculin serum that was not labeled was disposed of. 2 Any resident receiving a TB test could be affected. 3 All med rooms were audited to ensure all drugs and biologicals are labeled and dated. Staff re-educated and education will be provided during orientation and will	09/16/2024

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	08/23/2024

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, "Labels for stock medications include all necessary information, such as: the name and strength of the drug, the lot or control number, the expiration date when applicable, appropriate accessory and cautionary statements and directions for use...".		be ongoing. 4 Audits of med rooms will be completed 2 times a week times 4 weeks, weekly times 4 weeks, then bi-weekly for 4 weeks, monthly times one month, and quarterly thereafter. QA committee will review results to determine if further auditing should occur. Plan to be updated as indicated. 5 Alleged Compliance 9/16/24	