| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155029 | A. Building<br>B. Wing | 07/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Community Nursing and Rehabilitation Center | 5600 E 16th St<br>Indianapolis, IN 46218 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>Based on interview and record review, the facility failed to ensure a resident's choice was honored pertaining to selection of food items of their choice for 1 of 3 residents reviewed for resident rights. (Resident B)<br>Findings include: The clinical record for Resident B was reviewed on 7/14/25 at 3:50 p.m. The diagnoses included, but were not limited to, encephalopathy (group of conditions that cause brain dysfunction), hemiplegia (loss of strength leading to paralysis on one side of the body), and dysphagia (difficulty swallowing). A Significant Change Minimum Data Set (MDS) assessment, dated 6/3/25, indicated Resident B had moderate cognitive impairment, required substantial/maximal assistance with toileting hygiene, and was always incontinent of bowel and bladder. A care plan, last revised 5/28/25, indicated Resident B required assistance with activities of daily living (ADLs) including eating and toileting. The approach included to provide assistance with eating as needed and assistance with toileting and/or incontinent care as needed related to Resident B being incontinent of bowel and bladder. An incident reported to the Indiana Department of Health (IDOH), dated 6/11/25, indicated it was reported that Certified Nurse Aide (CNA) 2 was rude to Resident B during dining service. The investigation file was reviewed, on 7/14/25 at 4:00 p.m., and contained the following statements:A typed statement that pertained to what CNA 2 was referring to regarding Resident B. The statement indicated, I told the resident he wasn't [sic] giving him any chocolate milk because it runs through him and nobody got time for that. A typed statement that pertained to what Resident B had indicated during a staff interview regarding the incident with CNA 2. Resident B indicated he recalled the interaction between CNA 2 and himself. He stated he asked for chocolate milk and CNA 2 declined as it would upset his stomach. A typed statement that pertained to what Licensed Practical Nurse (LPN) 3 had witnessed regarding CNA 2 and Resident B. LPN 3 indicated, I was in the dining room between the hours of 12:39pm [12:39 p.m.] - 12:45p [12:45 p.m.]. As I was passing meds [medications]. I heard [name of CNA 2] say to [name of Resident B] as he asked for chocolate milk, 'No, I'm not getting you no chocolate milk, it's gonna have you going up your back - I don't have time for that'. An interview conducted with the Executive Director (ED), on 7/14/25 at 4:18 p.m., indicated CNA 2 was educated on residents' choice and preferences. The ED believed CNA 2 was attempting to advocate for Resident B, but the staff needed to honor Resident B's preferences. A policy entitled Preferences for Daily Routine, revised 12/2015, was provided by the ED on 7/14/25 at 4:39 p.m. The policy indicated the purpose was to identify and develop a plan of care that reflects a resident's past and current daily customary routines. The information would be shared with the interdisciplinary team so that each department can address the residents' preferences. This citation relates to Complaint IN00462929. 3.1-3(u)(1)3.1-3(u)(3) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155029 | A. Building<br>B. Wing | 07/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Community Nursing and Rehabilitation Center | 5600 E 16th St<br>Indianapolis, IN 46218 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>Based on observation, interview, and record review, the facility failed to timely implement a podiatry recommendation for 1 of 3 residents reviewed for foot care (Resident E).Findings include: The clinical record for Resident E was reviewed on 7/14/25 at 2:15 p.m. The resident's diagnosis included, but was not limited to, polyneuropathy (disorder of the nervous system).A physician's order, dated 9/25/24, indicated Resident E could be seen by the Podiatrist.On 7/14/25 at 2:45 p.m., Resident E was observed with the Director of Nursing (DON) in her room. She was lying in her bed, and her feet were observed to have thick, yellowing, crusty toenails on both big toes. Resident E indicated she had been seen by the Podiatrist recently.A Podiatry Group note, dated 6/14/25, indicated she had been seen by the Podiatrist and the nails on both feet had been debrided (reduced in size). There was a recommended new order of urea 40% cream (medication for dry skin and damaged nails) to all toenails daily for sixty days. The clinical record did not contain an order for urea 40% cream to be applied to Resident E's toenails daily for sixty days. During an interview on 7/14/25 at 4:15 p.m., the DON indicated when a resident had a podiatry recommendation it was normally given to her, and she processed the new order. The DON had not been made aware that Resident E had a recommended new order for urea cream. The urea cream should have been ordered. This citation relates to Complaint IN00463244.3.1-47(a)(7) |