STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Nursing and Rehabilitation Center	5600 E 16th St 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 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for receipt of physician-ordered medications received their ordered anti-convulsant (seizure prevention medications) and/or anti-anxiety medications as ordered for 3 consecutive days, resulting in an increase in the number of seizures and a hospitalization related to the increase in seizures. (Resident B) Findings include:The clinical record of Resident B was reviewed on 11-12-25 at 11:14 a.m. His diagnoses included, but were not limited to, traumatic hemorrhage of the cerebrum (brain bleed), seizures, general anxiety, impulse disorder, aphasia (does not speak/nonverbal). It indicated he was admitted to the facility on [DATE], from an area hospital. The most recent Minimum Data Set (MDS) assessment, dated 10-30-25, indicated the resident was severely cognitively impaired, was nonverbal, had no concerns with his short-term memory, but his long-term memory was affected. The current physician's order indicated the resident was to receive an anti-convulsant and anti-anxiety medications. He was dependent on the staff for most activities of daily living, such as bathing, toileting and physical movement and required the use of a wheelchair for mobility. A review of a progress note, from the attending Nurse Practitioner, dated 10-20-25, indicated Currently at neurological baseline but experiencing increased seizures due to lack of seizure medication administration since admission . Recommending transfer to ER [emergency room] for evaluation and treatment due to increased seizures and medication noncompliance. The Assessment/Plan portion of the note indicated Resident B's, Epilepsy, was not intractable .[had] increased seizure activity .[medications of] Phenobarbital, Ativan, Vimpat, Dilantin (not received since admission); Recommending transferring patient to ER for eval and treatment. A review of Resident B's progress notes, from 10-17-25 through 10-20-25, failed to acknowledge Resident B had not received any of the anti-convulsant medications or an anti-anxiety medication. The medication administration record (MAR) for the same time-period indicated the same medications, Phenobarbital, Ativan, Vimpat and Dilantin were unavailable for administration. The progress notes and the MAR failed to identify what steps, if any, had been taken to discover why the facility had not received the medications from the contracted pharmacy. The progress notes and MAR did not indicate any notifications had been made to the pharmacy, to the resident or resident's responsible party, the attending physician or facility administration regarding the lack of medication availability. A review of the physician's ordered medications for the resident not received were, specifically, Phenobarbital, Ativan, Vimpat and Dilantin. The resident's MAR was reviewed for the time period from 10-17-25 through 10-20-25, and indicated the following: - Phenobarbital 32.4 mg (milligrams) twice daily for seizures: 6 consecutive doses were not administered.- Phenobarbital 64.8 mg twice daily for seizures: 6 consecutive doses were not administered.- Ativan 2 mg three times daily for general anxiety: 7 consecutive doses were not administered. The morning dose, on 10-20-25, was documented as administered.- Vimpat 100 mg twice daily for seizures: 6 consecutive doses were not administered.- Dilantin 100 mg daily at bedtime for seizures: 3 consecutive doses were not administered.An additional medication, an anti-psychotic and identified for Resident B's use for general anxiety, olanzapine (Zyprexa) 10 mg twice daily was noted to have not been available for administration for five of six doses during the timeframe from 10-17-25 through 10-20-25. The MAR indicated Resident B was administered one dose of olanzapine 10mg on the admission evening of 10-17-25. In an interview with the Director of Nursing (DON), on 11-13-25 at 11:17 a.m., she indicated she learned about Resident B not having his anti-seizure or anti-anxiety meds until Monday morning, 10-20-25, when she read the Nurse Practitioner's note about him not receiving his meds and being sent out to the ER for evaluation for his increase in seizures during the night shift of 10-19-25 into 10-20-25. She shared her normal expectations for any new resident admission would be that each new admission/resident's meds should be received within 1-2 hours of admission. She indicated there has not been any formal investigation into this event at this point or any additional training or education for the nursing staff regarding lack of medications. She indicated her typical expectations for a resident not having meds available are to check the Omnicell (the facility's emergency drug device) for availability of the needed medications. If the meds are not available there, the nurse should then reach out to the MD to inform him/her the medication is unavailable [allowing] the MD the opportunity to write an order to hold or change the med to something different. The nurse should also reach out to the contracted pharmacy to stat [send emergently] the med out to the facility or discover what the holdup may be. The pharmacy should let the nurse know if there is an issue obtaining the med or if they might require a hard copy of the script. The nurse should also