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	12/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to maintain a resident's room in good repair contributing to a subsequent allegation of a resident for 1 of 3 residents reviewed for safe and clean environment. (Resident D)Findings include:The clinical record for Resident D was reviewed on 12/11/25 at 10:41 a.m. His diagnoses included, but were not limited to: major depressive disorder, cirrhosis of liver, liver transplant, severe alcohol dependence, and chronic kidney disease. The unedited 11/16/25, 7:33 a.m. nurse's note indicated, I was called to the first floor after a phone call from the police asking if there is problem. I replied that I would investigate. Upon reaching the first floor [name of Resident D] was yelling and accusing a new CNA [Certified Nursing Assistant] of pushing him. She did not. The plumbing broke and spilled water on the floor. This was apparently the trigger of his anger The investigative file into the allegation of staff to resident abuse involving Resident D and CNA (Certified Nursing Assistant) 2 was provided by the DNS (Director of Nursing Services) on 12/11/25 at 9:48 a.m. The file included the 11/17/25 documented interview with Resident D conducted by the SSD (Social Services Director.) It indicated Resident D reported that Sunday morning (11/16/25) nursing staff came into his shared room to get his roommate dressed for the day. Their normal routine was to turn on the water so that it could warm up. Staff left the water running unattended and moments later, water started to flood from the wall and around the bottom of the sink. Staff came in promptly to address the wet floors and provide the appropriate signage to be careful due to wet floors. Resident D indicated he told CNA 2 she should not have left the water unattended causing flooding on the floors. Resident D stated that CNA 2 asked him, Who are you talking to like that, and pushed him out of the way and exited his room. An interview was conducted with CNA 2 on 12/11/25 at 12:24 p.m. She indicated she currently worked at the facility as a CNA and was still within her first 90 days of employment. The morning of 11/16/25, she assisted Resident D's roommate with incontinence care, which involved running the water in the sink. She turned the water off prior to exiting the room. About an hour later, a co-worker informed her that there was water all over the floor in Resident D's room. CNA 2 retrieved a towel and went into the room to clean up the water. After entering the room, Resident D accused her of causing the water on the floor. Resident D thought she was responsible, because she was the last person in the room to use the sink. CNA 2 stated, I swear I don't remember leaving the water on. CNA 2 informed Resident D she did not leave the water running in the room and walked away. She did not ask him who he was talking to like that or push him out of the way to exit the room. When Resident D jumped off his bed, he flopped into his wheelchair, which wasn't locked, so it went backwards. Then Resident D immediately accused her of pushing him. CNA 2 was standing near the door at this time, like six feet away, from Resident D. She was in the room for less than two minutes.An interview and observation were conducted with Resident D in his room on 12/11/25 at 12:46 p.m. There was a small sink in the room against the wall. The drainpipe coming from the sink, leading into the wall, was easily visible. The wall to the right of the sink had ripples, bubbles, and peeling paint leading from the bottom of the wall up 4 feet, as well as missing baseboard. The bottom right part of the wall was dark in color. Resident D indicated the bubbles in the wall were from water damage. The sink did not overflow. It was the drain return pipe leading into the wall that leaked. He'd told the maintenance director about it a thousand times, and filled out a work order for it eight months ago. When the drainpipe leaked, water went into the hallway as well. The maintenance director doesn't do anything. When the CNAs came into his room to assist his roommate with incontinence care, the first thing they did was turn the water on, as it took a while for the water to warm. The plumbing can't take running water for too long. After the water ran from the room, it would then run down the hallway and staff had to put out the yellow wet floor sign. Staff had to use a bunch of towels, so no one slipped on the water. This occurrence happened routinely, about once a month. He was worried about the potential of breathing in mold as he believed his immune system was compromised. The water had been leaking, and the wall had looked like this since he'd lived in the room. The census tab of the electronic health record indicated Resident D began residing in his room on 3/2/25. On 12/11/25 at 1:04 p.m., an interview and observation of Resident D's room were conducted with the HS (Housekeeping Supervisor,) as the Maintenance Director was unavailable. The HS indicated he noticed the condition of Resident D's wall before. It looked like structural damage to him, but he was unsure what was happening. The facility was supposed to begin renovations sometime after Thanksgiving (11/27/25,) but they hadn't yet begun. The Resident's Rights policy was provided by the DNS on 12/11/25 at 2:02 p.m. It indicated, The Resident has a right to prompt efforts by

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to report an allegation of staff to resident abuse to the ED (Executive Director) and IDOH (Indiana Department of Health) timely for 1 of 3 residents reviewed for abuse. (Resident D)Findings include: The clinical record for Resident D was reviewed on 12/11/25 at 10:41 a.m. His diagnoses included, but were not limited to: major depressive disorder, cirrhosis of liver, liver transplant, severe alcohol dependence, and chronic kidney disease. The 11/16/25, 7:00 a.m. nurse's note indicated, This writer was notified by a CNA that resident was cursing at her and yelling out false Accusations at approx [approximately] 5 am, situation began because of leaking water, staff was removed from res [resident's] room assignment and this writer instructed the staff to contact the ED [Executive Director] and DNS [Director of Nursing Services,] CNA [Certified Nursing Assistant] spoke with DNS and DNS reported the situation to the ED, statements were written and left in ED office, Nurse on night shift was aware of situation and spoke with the resident. MD was notified, res has no listed Emergency Contact. Will cont [continue] to monitor. Res currently in good spirits and talking nicely to the staff, he is requesting his colostomy supplies be re-ordered when next order is processed, resident states.An interview was conducted with CNA (Certified Nursing Assistant) 2 on 12/11/25 at 12:24 p.m. She indicated she currently worked at the facility as a CNA and was still within her first 90 days of employment. The morning of 11/16/25, she assisted Resident D's roommate with incontinence care, which involved running the water in the sink. She turned the water off prior to exiting the room. About an hour later, a co-worker informed her that there was water all over the floor in Resident D's room. CNA 2 retrieved a towel and went into the room to clean up the water. After entering the room, Resident D accused her of causing the water on the floor. Resident D thought she was responsible, because she was the last person in the room to use the sink. CNA 2 stated, I swear I don't remember leaving the water on. CNA 2 informed Resident D she did not leave the water running in the room and walked away. She did not ask him who he was talking to like that or push him out of the way to exit the room. When Resident D jumped off his bed, he flopped into his wheelchair, which wasn't locked, so it went backwards. Then Resident D immediately accused her of pushing him. CNA 2 was standing near the door at this time, like six feet away, from Resident D. She was in the room for less than two minutes. The investigation file into the above allegation of staff to resident abuse involving Resident D and CNA (Certified Nursing Assistant) 2 was provided by the DON (Director of Nursing) on 12/11/25 at 9:48 a.m. The file included the 11/20/25 follow-up incident report. It indicated the incident date and time was on 11/17/25 at 11:01 a.m. It was reported to IDOH on 11/17/25 by the ED (Executive Director.] The file included the 11/17/25 documented interview with Resident D conducted by the SSD (Social Services Director.) It indicated Resident D reported that Sunday morning (11/16/25) nursing staff came into his shared room to get his roommate dressed for the day. Their normal routine was to turn on the water so that it could warm up. Staff left the water running unattended and moments later, water started to flood from the wall and around the bottom of the sink. Staff came in promptly to address the wet floors and provide the appropriate signage to be careful due to wet floors. Resident D stated he told CNA 2 she should not have left the water unattended causing flooding on the floors. Resident D stated that CNA 2 asked him, Who are you talking to like that, and pushed him out of the way and exited his room. An interview was conducted with the DNS on 12/11/25 at 1:16 p.m. She indicated she reported the allegation to the ED on 11/16/25, the day it occurred. The ED was unavailable in the facility for interview.An interview was conducted with the RDCS (Regional Director of Clinical Services) on 12/11/25 at 12:24 p.m. She indicated the allegation should have been reported to the ED and IDOH immediately. It was her understanding the ED reported to IDOH immediately upon finding out about the allegation, which wasn't until 11/17/25. The Abuse Prohibition, Reporting, and Investigation policy was provided by the RDCS on 12/11/25 at 12:50 p.m. It indicated, Identification: Abuse includes: 1. Staff to resident abuse of any type.Types of abuse: 1. Verbal abuse.4. Physical abuse.Resident Abuse - Staff member, volunteer, or visitor: .2. Any individual who witnesses abuse, or has suspicion of abuse, shall immediately notify the charge nurse of the unit, which the resident resides and to the Executive Director.4. The Executive Director and/or Director of Nursing will be immediately notified of the report and the initiation of the investigation. Reporting/Response: 1. All abuse allegations must be reported to the Executive Director immediately. Failure to report will result in disciplinary action, up to and including immediate termination. 2. The Executive Director will ensure that if the alleged violation involves abuse or results in serious bodily injury, it must be reported immediately but no later than 2 hours to the Long-Term Care

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to provide incontinent care timely for a dependent resident for 1 of 3 residents reviewed for Activities of Daily Living (ADL) assistance (Resident F). Finding include:Review of the clinical record of Resident F on 12/10/25 at 11:08 a.m., indicated the resident's diagnoses included, but were not limited to, heart failure, peripheral vascular disease, diabetes, muscle weakness, anxiety disorder and major depressive disorder. The plan of care for Resident F, dated 8/18/25, indicated the resident required assistance with ADL's. The interventions included, but were not limited to, assist with grooming, hygiene, toileting and incontinent care as needed. The resident concern/grievance form for Resident F, dated 11/10/25, indicated the resident's concern was she would turn on her call light to be provided incontinent care and the incontinent care was not provided in a timely manner resulting in the resident sitting in her own waste. The resident indicated this happened often. The grievance was marked resolved on 11/15/25 and indicated Resident F indicated care had gotten better, but there still were times it happened. The grievance was completed by the admission Coordinator. The quarterly Minimum Data Set (MDS) assessment for Resident F, dated 11/18/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident had no behaviors of rejection of care. The resident was dependent on staff for toileting. The resident was always incontinent of urine and frequently incontinent of bowels. During an interview and observation with Resident F on 12/10/25 at 11:32 a.m., the resident indicated it was disrespectful to her when staff did not answer her call light and would leave her wet and dirty. The resident indicated it hurt her feelings and it made her cry. The staff left her in urine and bowel movement for hours. The resident indicated she had a cell phone and timed how long it took for staff to provide care to her. The admission Coordinator came and seen her every morning and the resident did report these concerns to her. The resident indicated she was currently lying in urine and had been for an hour. The resident activated her call light. CNA 3 and the Assistant Director of Nursing Services (ADNS) came in and provided Resident F with incontinent care. The resident's brief was urine soaked and two cloth incontinent pads were also soaked in urine. During an interview with the admission Coordinator on 12/10/25 at 1:35 p.m., indicated she was Resident's F care companion and she visited her every morning. The admission Coordinator indicated she did fill out a grievance for Resident F related to not getting incontinent care timely. The admission Coordinator indicated after the grievance was filed Resident F continued to report to her that her call light was not answered timely and incontinent care was not provided timely. The admission Coordinator indicated she always reported Resident F's concerns in morning meeting. During an interview with the Director of Nursing Services (DNS) on 12/11/25 at 1:00 p.m., the DNS indicated it was the facilities expectation that when residents were incontinent of urine or bowel movement, incontinent care should be provided immediately. This Citation relates to Intake 2667249. 3.1-38(a)(3)(A)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to transport a resident in wheelchair in a safe manner and failed to provide adequate monitoring for a resident who exited the facility without a responsible party for 2 of 3 residents reviewed for accidents (Resident F and Resident B). Findings include:1. Review of the clinical record of Resident F on 12/10/25 at 11:08 a.m., indicated the resident's diagnoses included, but were not limited to, heart failure, peripheral vascular disease, diabetes, muscle weakness, anxiety disorder and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment for Resident F, dated 11/18/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident utilized a wheelchair for transportation and was dependent on staff for transport in the wheelchair. The resident did not ambulate. The progress note for Resident F, dated 9/20/25 at 2:13 p.m., indicated the resident complained of right foot pain. The resident's right foot was swollen and painful to the touch. An physician's order was received for the resident to obtain an x-ray of the right foot. The radiology report for Resident F, dated 9/21/25, indicated there was no fracture to the right foot. The witness statement, dated 10/18/25, indicated CNA 4 admitted pushing Resident F in the wheelchair in September 2025 and accidently hit the resident's foot on the door entry when trying to turn into the resident's room. The witness statement from Resident F, dated 10/18/25, indicated in September 2025, CNA 4 was pushing her in the wheelchair and accidentally rammed her foot into the wall when she was turning the wheelchair into the resident's room. During an interview with the Director Of Nursing Services (DNS) on 12/11/25 at 10:37 a.m., indicated Resident F had complained of pain of her legs and feet in October 2025 and called emergency services. The resident returned to the facility with a fractured right toe. The DNS indicated she started an investigation. Resident F reported to her that in September 2025, CNA 4 was pushing her down the hallway and hit her right foot on the wall when she was turning into the resident's room. The DNS indicated she talked to CNA 4 and the CNA indicated she accidently hit the resident's right foot on the wall when transporting her in the wheelchair. CNA 4 reported it to the Unit Manager. The Unit Manager had an x-ray completed and there was no fracture. The DNS indicated she did not do any safety training with the staff or implement in interventions to prevent an accident like this to happen again. During an interview with the DNS on 12/11/25 at 11:23 a.m., the DON indicated the facility did not have a accident policy. During an interview with the Regional Director Of Clinical Services on 12/11/25 at 12:50 p.m., indicated the facility did not have a policy on transporting residents in wheelchairs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DNS on 12/11/25 at 1:00 p.m., indicated the facilities expectations for staff transporting dependent residents in their wheelchair was to transport the residents in a safe and slow manner down the hallway and to watch their surroundings and make ensure there was enough clearance/room when going around corners. 2. The clinical record for Resident B was reviewed on 12/10/25 at 11:10 a.m. His diagnoses included, but were not limited to: schizoaffective disorder, bipolar type, post-traumatic stress disorder, and anxiety. He was readmitted to the facility on [DATE] after an in-patient psychiatric hospitalization. The Quarterly MDS (Minimum Data Set) assessment, dated 11/10/25, indicated he was cognitively intact. The physician's orders indicated he may go LOA (leave of absence) with responsible party and medications, effective 8/8/25. The 11/13/25, 2:30 p.m. nurse's note indicated, Resident observed in between front double doors with grocery bag in hand. Writer assisted resident back inside building. Resident stated he went to gas station for pop and chips. Writer informed resident he should not leave the building without staff due to safety and if he needs snacks the staff can get it for him. Weather was sunny and resident was dressed appropriately. No visible injuries noted. Writer assisted resident back to room for head to toe assessment no abnormalities noted. Full set of vitals completed and within normal limits. ED [Executive Director,] SSD [Social Services Director,] and Family notified. The IDT (Interdisciplinary Team) note, dated 11/14/25, written by the SSD, indicated, Description of behavior: Resident excited [sic] building to go to gas station to get snacks. Immediate interventions: Resident was assessed by staff and educated on following the loa policy. Also staff informed resident that facility will provide snacks. Assessment of potential correlation to root cause: Psychiatric conditions (depression, anxiety, psychosis, etc.) Dx of schizoaffective disorder bipolar type. Root cause of behavioral expression: Due to resident's dx [diagnosis] of schizoaffective disorder he has a behavioral expressions of impulsiveness. Describe preventative intervention relating to above root cause: Resident was assessed and given a Wanderguard for safety due to fluctuating Bims [brief interview for mental status.] Care plan updated and current interventions revised as applicable: Yes. Communication provided as to above intervention.: yes. An interview was conducted with the DNS and RDCS (Regional Director of Clinical Services) on 12/10/25 at 1:43 p.m. The DNS indicated she was present in the facility when Resident B returned to the facility on [DATE] after he was LOA without a responsible party. The RDCS indicated he was gone around 30 minutes. He had a BIMS of 15 and knew where he was going, but his physician did not think he should be LOA without a responsible party. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation file into Resident B's 11/13/25 LOA was provided by the RDCS on 12/10/25 at 12:30 p.m. It included an 11/14/25 progress note, written by Physician 5, Resident B's physician. It indicated, Informed today that the patient had left the facility but returned after he had purchased snack and a drink. It appears that the patient waited by the front door and slipped out when other visitors were leaving. It was not an incident in which he wandered out of the facility, it was intentional. Although he has a BIMS of 15, there are periods of time where that BIMS is not 15. He has dx of schizoaffective disorder and has episodes of cycling. During these periods of cycling, he is manic and behavior is unpredictable (has required several hospitalizations due to behaviors) and it is difficult to reason with him. He has hx [history] of impulsive behavior and poor decision making. I would NOT recommend patient have an independent LOA. I agree that a wanderguard should be placed for patient protection. I would be very concerned that if he were to leave again that his behavior could potentially put him at risk for injury. If he were to be outside of the facility alone and encountered a situation that was overwhelming, he could potentially be injured not just physically. His mental and emotional status needs to be protected as much as possible. If there was a responsible friend or family member who was willing to take him out, that would be acceptable. An interview was conducted with Resident B's guardian, Family Member 6, on 12/10/25 at 1:10 p.m. He indicated he was not okay with Resident B having left the facility alone on 11/13/25. He might take off somewhere, get hurt, get lost, anything. An observation of Resident B was made on 12/11/25 at 10:17 a.m. He was asleep and unavailable for interview. There was a wanderguard on his right ankle. The Leave of Absence policy was provided by the DNS on 12/11/25 at 9:48 a.m. It indicated, It is the policy of this facility that continuity of care and safety during resident Leave of Absence will be maintained. Leave of absence requires a physician's order.Procedure: .2. Nursing will obtain a physician's order for leave of absence with responsible person and medications, as appropriate.9. If the resident desires to leave the facility independently, please refer to the Independent LOA policy. The Independent Leave of Absence policy was provided by the DNS on 12/11/25 at 11:30 a.m. It indicated, Leave of absence requires a physician's order. This Citation relates to Intakes 2667249 and 2670004

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to provide oxygen as ordered by the physician and failed to maintain oxygen tubing and humidifier bottle in a sanitary manner for 1 of 1 random observation of oxygen use (Resident F). Review of the clinical record of Resident F on 12/10/25 at 11:08 a.m. , indicated the resident's diagnoses included, but were not limited to, heart failure, peripheral vascular disease, diabetes, muscle weakness, anxiety disorder and major depressive disorder. The plan of care for Resident F, dated 8/18/25, indicated the resident had impaired gas exchange and utilized oxygen. The interventions included, but were not limited to, administer oxygen as ordered. The December 2025 physician order for Resident F, indicated she was ordered oxygen 3 liters per nasal cannula every shift and change tubing and humidity every week on Sunday. The quarterly Minimum Data Set (MDS) assessment for Resident F, dated 11/18/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. During an interview and observation with Resident F on 12/10/25 at 11:32 a.m., the resident's oxygen tubing and humidifier bottle was lying on the floor, neither one had a date on it. The resident's oxygen was set a 3 liters. Resident F indicated someone was supposed to get her new oxygen tubing and humidifier bottle, but they had not yet. The resident indicated she had been waiting for an hour for her oxygen to be fixed. The resident indicated her oxygen concentrator had been broke a long time and the humidifier bottle always sat on the floor. The resident activated her call light. The Assistant of Nursing Services (ADNS) indicated the nurse was supposed to care for Resident F's oxygen tubing and humidifier bottle. The ADNS brought in new oxygen tubing and a new humidifier bottle and dated both. The ADNS indicated the resident's oxygen concentrator strap was broke to hold the humidifier water and she would attempt to find another oxygen concentrator. The ADNS was unable to find another oxygen concentrator and placed the humidifier bottle in a bag so it was not in direct contact with the floor. The ADNS checked Resident F's oxygen saturations and it was between 92-94 % without the oxygen in place, when the ADNS provided Resident F with her oxygen, the resident's oxygen saturation went up to 99%.During an interview with the Director Of Nursing Services (DNS) on 12/11/25 at 1:00 p.m., indicated it was the facilities expectation that staff would ensure residents were receiving oxygen as ordered by the physician and the tubing and humidifer bottle should be dated. This Citation relates to Intake 2667249. 3.1-47(a)(6)