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	04/23/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to timely initiate physician's orders for 1 of 2 residents reviewed for skin conditions. (Resident 23) Findings include: The clinical record for Resident 23 was reviewed on 4/20/26 at 8:30 a.m. The resident's diagnosis included, but was not limited to, chronic peripheral venous insufficiency (condition that prevented blood from returning to heart and caused blood to pool in lower extremities) A Quarterly Minimum Data Set (MDS) Assessment, completed 3/25/26, indicated the resident had moderately impaired cognition and had no foot problems. A physician's order, dated 4/15/26, indicated the resident's right foot was to be wrapped in kerlix (type of gauze dressing) daily. The order was discontinued on 4/17/26. A care plan, initiated 4/16/26, indicated Resident 23 had an open blister on his right foot. He had intermittent edema (swelling) of his feet. He had a history of refusing treatments and labs at times. The goal was for the wound to heal without complications. A Skin and Wound note, dated 4/17/26, indicated Resident 23 had been seen for a new skin issue of a large blister on the top of his right foot that extended to the right great toe and was suggestive of cellulitis. The blister had opened and the area around the wound was edematous (swollen), had redness, was warm and tender to touch. It was recommended to reach out to the primary care physician for an oral antibiotic (medication to treat infection). The wound on the top of the right foot was to be treated with Xeroform (a type of wound dressing) and secured with an ABD pad (thick, absorbent dressing) and kerlix gauze. The wound dressing should have been changed every other day and as needed. A physician's order, dated 4/17/26, indicated the resident was to receive linezolid (antibiotic) 600 milligrams (mg) every 12 hours for 10 doses. Resident 23's clinical record did not contain an order for the Xeroform wound dressing. The April 2026 Medication Administration Record (MAR) indicated Resident 23 did not receive linezolid 600 mg on 4/17, 4/18, 4/19, and 4/20/26 at 7:00 a.m.On 4/20/2026 at 11:16 a.m., Resident 23 was observed in the hallway. The resident's right foot had an unraveling kerlix dressing with tan colored drainage visible on the top of the dressing. On 4/21/26 at 10:34 a.m., Resident 23 was observed in his room. The resident had a clean kerlix dressing on his right foot.A physician's order, dated 4/21/26, indicated the resident was to have right foot wound cleansed and covered with xeroform, covered with an ABD and wrapped in kerlix. The wound dressing was to be changed every other day and as needed. During an interview on 4/21/2026 at 11:34 a.m., Licensed Practical Nurse (LPN) 2 indicated the resident had received a dose of linezolid that morning. LPN 2 removed Resident 23's linezolid medication from the medication cart. The linezolid had been dispensed by the pharmacy on 4/17/26 and 2 of the 10 doses dispensed had been given. LPN 2 was unsure why only 2 doses had been administered. During an interview on 4/22/26 at 11:42 a.m., the Regional Director of Clinical Services indicated Resident 23's antibiotic and wound treatment should have been started when ordered by the physician. On 4/22/26 at 11:42 a.m., the Regional Director of Clinical Services provided the Skin Management Program, dated May 2022, that read .Alterations in skin integrity will be reported to the MD/NP [sic] .Treatment orders will be obtained from the MD/NP [sic] . 410 IAC (Indiana Administrative Code) 16.3.1-37

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review, the facility failed to timely address residents' missing eyeglasses, ensure an ophthalmologist appointment was made and eye drops were administered as ordered for 2 of 3 residents reviewed for vision services. (Residents 8 and 10) Findings include:1.The clinical record for Resident 8 was reviewed on 4/20/26 at 8:30 a.m. The diagnosis included but was not limited to: dry eye syndrome (eyes do not produce enough tears). A Quarterly Minimum Data Set (MDS) Assessment, dated 3/31/26, indicated Resident 8 was cognitively intact. An eye visit report, dated 11/14/25, indicated Resident 8 has lost her eyeglasses. The eye doctor had recommended a new set of bifocals upon approval. An interview was conducted with Resident 8 on 4/20/26 at 8:42 a.m. She indicated she needed eyeglasses. She did have some, but they have been missing for a while. An interview was conducted with Certified Nursing Assistant (CNA) 3 on 4/22/26 at 10:24 a.m. She indicated Resident 8 did wear eyeglasses, but the eyeglasses were unable to be found. An interview was conducted with the Administrator on 4/23/26 at 8:52 a.m. She indicated she had spoken to the Social Services Director (SSD). The SSD reported Resident 8's eyeglasses were missing. She was unaware the eyeglasses were missing until that day. 2. The clinical record for Resident 10 was reviewed on 4/20/26 at 7:30 a.m. The diagnosis included but was not limited to: schizoaffective disorder (a chronic mental mood disorder with hallucinations and delusions.) A Quarterly MDS Assessment, dated 3/25/26, indicated Resident 10 was cognitively intact. A physician's order, dated 4/20/26, indicated the staff were to make an ophthalmology (specialized eye services) consultation. A physician's order, dated 4/20/26, indicated Resident 10 was to receive brimonidine eye drops in both eyes twice a day. An interview was conducted with Resident 10 on 4/20/26 at 7:57 a.m. He indicated he was supposed to have cataract eye surgery. He was unsure when it was scheduled. An eye visit report, dated 2/4/26, indicated the provider had recommended Resident 10 to have cataract surgery. The provider ordered ophthalmology consultation and brimonidine eye drops were to be administered to the resident in both eyes twice a day. The resident had lost his eyeglasses. New bifocals would be delivered upon approval. An interview was conducted with the Regional Director of Clinical Services (RDCS) on 4/22/26 at 11:00 a.m. She indicated Resident 10 had asked the nurse on 4/20/26 about his cataract surgery. The eye visit report was reviewed. The recommendations for ophthalmology consultation, and the brimonidine eye drops that had been ordered on 2/4/26 were missed. A Vision services policy was provided by the RDCS on 4/22/26 at 11:43 p.m. It indicated, .Policy. It is the policy of this facility to ensure that residents are provided with vision and hearing services as needed.Nursing provides for proper care of glasses,. 410 IAC (Indiana Administrative Code) 16.3-3.1-39(a)(1)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to provide fluids at the bedside for 1 of 2 residents reviewed for hydration. (Resident C) Findings include:The clinical record for Resident C was reviewed on 4/21/2026 at 9:58 a.m. The diagnoses included, but were not limited to, dementia, anxiety, and hypothyroidism (the thyroid gland fails to produce enough hormones, slowing metabolism). A physician's order, dated 5/1/25, indicated Resident C had a regular diet order with thin liquids. During an observation on 4/20/26 at 7:39 a.m., Resident C had a small clear cup of pink liquid sitting on a table across the room from Resident C's bed. During an observation on 4/21/26 at 10:27 a.m. and 2:13 p.m., Resident C did not have any fluids in her room or at her bedside. Resident C's bedside table was adjacent to her bed with a pillow lying on top. An observation of Resident C on 4/21/26 at 12:40 p.m., indicated she could independently hold a cup and drink through a straw without difficulties. During an observation on 4/23/26 at 9:50 a.m., Resident C had no fluids in her room or at her bedside. A Significant Change Minimum Data Set (MDS) assessment, dated 4/1/26, indicated Resident C was moderately cognitively impaired and required substantial/maximal assist with eating. A plan of care, dated 4/25/25, indicated Resident C had potential for tiredness and weakness due to the diagnosis of anemia. The interventions included, but were not limited to, encourage fluids. A plan of care, dated 4/25/25, indicated Resident C was at risk for fluid imbalance due to dementia and hypothyroidism. The interventions included, but were not limited to, encourage fluids. During an interview with Licensed Practical Nurse (LPN) 2 on 4/23/26 at 9:56 a.m., indicated staff should be passing ice waters and she did not know why Resident C did not receive any ice water that morning. LPN 2 indicated waters were passed to residents every shift and as needed. Certified Nursing Assistants (CNAs) were assigned to pass waters, but any staff member can pass water if needed. A Hydration Management policy was provided by the Senior Administrator on 4/23/26 at 11:00 a.m. It indicated .Policy: It is the policy of American Senior Communities to ensure that each resident is offered sufficient fluid intake to maintain proper hydration.Procedure: 9. Fresh water or other preferred beverages will be passed to all residents on each shift.10. A variety of additional fluids will be offered at various times throughout each shift. 410 IAC (Indiana Administrative Code) 3.1-46

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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 follow a physician's order to change humidified oxygen for 1 of 2 residents reviewed for respiratory care. (Resident C) Findings include:The clinical record for Resident C was reviewed on 4/21/2026 at 9:58 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, chronic obstructive pulmonary disease (a progressive lung disease that restricts airflow), and anxiety. A plan of care, dated 4/25/25, indicated Resident C had the potential for impaired gas exchange due to chronic obstructive pulmonary disease. The interventions included, but were not limited to, administer oxygen as ordered. A Significant Change Minimum Data Set (MDS) assessment, dated 4/1/26, indicated Resident C was moderately cognitively impaired and received oxygen therapy. During an observation on 4/20/26 at 7:40 a.m., Resident C had an empty bottle of humidified oxygen, dated 4/13/26, hooked up to her oxygen concentrator. The April 2026 Medication Administration Record (MAR) indicated Resident C had a new bottle of humidity hung 4/19/26 between 11:00 p.m. to 7:00 a.m. A physician's order, dated 3/26/26, indicated staff were to change the resident's oxygen tubing and humidity once a day on Sunday. During an observation on 4/20/26 at 10:33 a.m., Resident C had a new humidity bottle, dated 4/19/26, hooked up to her oxygen concentrator. During an interview with Licensed Practical Nurse (LPN) 2 on 4/21/26 at 10:33 a.m., they indicated the LPN did not know who hung the new bottle of humidity or why it was dated 4/19/26 when it was hung on 4/20/26. LPN 2 indicated they normally would put the correct date and initials on a new bottle hung. During an interview with the Minimum Data Set (MDS) assessment Nurse on 4/21/26 at 10:45 a.m., they indicated they went in to change the oxygen humidity bottle on 4/20/26 with LPN 4 because they noticed it was empty and she must have put the wrong date on the bottle. During an interview with the Regional Director of Clinical Services on 4/23/26 at 9:38 a.m., indicated on Sunday 4/19/26, the unit manager should have changed the humidified oxygen bottle as it was ordered on the MAR or as needed. Her expectation was that staff follow physician orders. This Citation relates to intake 2808585410 IAC (Indiana Administrative Code) 3.1-47(a)(6)

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F 0755 Level of Harm - Minimal harm or potential for 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. Based on observation, interview, and record review, the facility and the facility-contracted pharmacy failed to ensure an excessive dose of a medication was not administered to a resident for 1 of 5 residents reviewed for unnecessary medications (Resident B).Findings include: The clinical record for Resident B was reviewed on 4/20/26 at 10:12 a.m. The resident's diagnoses included, but were not limited to, diabetes and morbid (severe) obesity due to excess calories. A Quarterly Minimum Data Set (MDS) Assessment, completed 2/16/26, indicated Resident B was cognitively intact. A care plan, last reviewed 1/16/26, indicated the resident was at risk for adverse effects of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar) related to the use of glucose (blood sugar) lowering medications and a diagnosis of diabetes. The goal was for the resident not to experience hyperglycemia or hypoglycemia. The interventions included, but were not limited to, observe for signs and symptoms of hyperglycemia and hypoglycemia, monitor blood sugar as ordered, and administer medications as ordered. A physician's order, dated 12/2/25, indicated the resident was to receive Ozempic (medication given once a week to improve blood sugar control) 0.5 milligram (mg) subcutaneously (injected into the subcutaneous tissue) every Tuesday. This order was discontinued on 1/27/26. A physician's order, dated 1/20/26 with a start date of 1/27/26, indicated the resident was to receive Ozempic 1 mg/dose (4mg/3ml); 4 mg subcutaneously every Tuesday.A physician's progress note, dated 1/20/26, indicated Resident B's Ozempic was to be increased to 4 mg weekly. The first dose was to be given on 1/27/26.A pharmacy review, conducted 2/4/26, did not contain recommendations about Resident B's Ozempic dosage.The February 2026 Medication Administration Record (MAR) indicated Resident 23 had received Ozempic 1 mg/dose (4mg/3ml); 4 mg subcutaneously on 2/3, 2/17, and 2/24/26.A pharmacy review, conducted 3/5/26, did not contain recommendations about Resident 23's Ozempic dosage. The March 2026 MAR did not contain documentation that Resident B had received her scheduled dose of Ozempic on 3/3 and 3/10/26. The March 2026 MAR did indicate the resident had received Ozempic 1 mg/dose (4mg/3ml); 4 mg subcutaneously on 3/24 and 3/31/26.During an interview on 4/20/26 at 10:12 a.m., Resident B indicated she had not been getting her scheduled shots on Tuesdays. The April 2026 MAR did not contain documentation that Resident B had received her scheduled dose of Ozempic on 4/7/26. The resident had received the scheduled dose of Ozempic on 4/14/26. The 4/21/26 dose indicated had not been given and a note indicated awaiting pharmacy.During an interview on 4/23/26 at 1:26 p.m., Pharmacy Technician (PTC) 5 indicated the resident's Ozempic had been refilled by the pharmacy on 2/17/26 and four doses had been sent. The Ozempic had also been refilled on 4/9/26 and four doses had been sent to the facility. The facility should have had the Ozempic available to be given.On 4/23/24 at 1:30 p.m., the facility medication room refrigerator was observed with Licensed Practical Nurse (LPN) 4. LPN 4 indicated the facility medication refrigerator did not contain Resident B's Ozempic medication. Ozempic was normally stored in the medication refrigerator.During an interview on 4/23/26 at 2:10 p.m., the Director of Nursing (DON) indicated Resident B had been receiving 4 mg of Ozempic as ordered by the Nurse Practitioner.During an interview on 4/23/26 at 2:15 p.m., Registered Pharmacist (RP) 7 indicated the pharmacy had received an order for Ozempic 1 mg/dose (4mg/3ml); 4 mg subcutaneously and had clarified the order with Nurse Practitioner (NP) 8 on 1/30/26. The clarified Ozempic order was for the resident to receive 1 mg of Ozempic every Tuesday. The pharmacy had sent an Ozempic multidose pen that contained 4 one milligram doses on 4/9/26. The maximum dose of Ozempic was two milligrams weekly. The pharmacy would not have filled the prescription for Ozempic 4 mg weekly as it would have exceed the maximum dosage.During an interview on 4/23/26 at 2:20 p.m., the Administrator indicated NP 8 did not work at the facility and the facility was unaware of who NP 8 was and the facility did not have an order on record for Resident B to receive Ozempic 1 mg weekly. The Ozempic physician's order the facility had been (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following for 4 mg weekly.During an interview on 4/23/26 at 2:29 p.m., NP 6 indicated she had increased Resident B's Ozempic on 1/20/26. NP 6 could not recall the amount of Ozempic ordered but would not have intended to order an inappropriate dose. The Ozempic.injection, for subcutaneous use Medication Guide, dated October 2025, was retrieved from Ozempic.com website on 4/24/26 at 2:00 p.m. The Ozempic Medication Guide read .2.2 Recommended Dosage.The maximum recommended dosage is 2 mg once weekly. This citation was related to Intake 2808585 410 IAC (Indiana Administrative Code) 16.3.1-25(i)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure a physician's order was clearly written for 1 of 5 residents reviewed for resident records. (Resident B)Findings include: The clinical record for Resident B was reviewed on 4/20/26 at 10:12 a.m. The resident's diagnoses included, but were not limited to, diabetes and morbid (severe) obesity due to excess calories. A Quarterly Minimum Data Set (MDS) Assessment, completed 2/16/26, indicated Resident B was cognitively intact. A physician's order, dated 1/20/26 with a start date of 1/27/26, indicated the resident was to receive Ozempic 1 mg/dose (4mg/3ml); 4 mg subcutaneously every Tuesday.A physician's progress note, dated 1/20/26, indicated Resident B's Ozempic was to be increased to 4 mg weekly. The first dose was to be given on 1/27/26.The March 2026 MAR did not contain documentation that Resident B had received her scheduled dose of Ozempic on 3/3 and 3/10/26. The March 2026 MAR did indicate the resident had received Ozempic 1 mg/dose (4mg/3ml); 4 mg subcutaneously on 3/24 and 3/31/26. The April 2026 MAR did not contain documentation that Resident B had received her scheduled dose of Ozempic on 4/7/26. The resident had received the scheduled dose of Ozempic on 4/14/26. The 4/21/26 dose indicated had not been given and a note indicated awaiting pharmacy. During an interview on 4/23/26 at 2:10 p.m., the Director of Nursing (DON) indicated Resident B had been receiving 4 mg of Ozempic as ordered by the Nurse Practitioner.During an interview on 4/23/26 at 2:15 p.m., Registered Pharmacist (RP) 7 indicated the pharmacy had received an order for Ozempic 1 mg/dose (4mg/3ml); 4 mg subcutaneously and had clarified the order with Nurse Practitioner (NP) 8 on 1/30/26. The clarified Ozempic order was for the resident to receive 1 mg of Ozempic every Tuesday. The pharmacy had sent an Ozempic multidose pen that contained 4 one milligram doses on 4/9/26. The maximum dose of Ozempic was two milligrams weekly. The pharmacy would not have filled the prescription for Ozempic 4 mg weekly as it would have exceed the maximum dosage.During an interview on 4/23/26 at 2:20 p.m., the Administrator indicated NP 8 did not work at the facility and the facility was unaware of who NP 8 was and the facility did not have an order on record for Resident B to receive Ozempic 1 mg weekly. The Ozempic physician's order the facility had been following for 4 mg weekly.During an interview on 4/23/26 at 2:29 p.m., NP 6 indicated she had increased Resident B's Ozempic on 1/20/26. NP 6 could not recall the amount of Ozempic ordered but would not have intended to order an inappropriate dose. The Ozempic.injection, for subcutaneous use Medication Guide, dated October 2025, was retrieved from Ozempic.com website on 4/24/26 at 2:00 p.m. The Ozempic Medication Guide read .2.2 Recommended Dosage.The maximum recommended dosage is 2 mg once weekly.This citation was related to Intake 2808585410 IAC (Indiana Administrative Code) 16.3.1-50(a)(2)