STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(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 Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on April 25, 2025. This visit included a PSR to the Investigation of Complaint IN00456672 completed on April 25, 2025. Complaint IN00456672 - Corrected. Survey dates: June 10, 2025 Facility number: 000012 Provider number: 155029 AIM number: 100274900 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 1 Medicaid: 47 Other: 7 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 10, 2025.	F 0000	The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally requests a desk review of the following plans of correction	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure cleanliness of the kitchen. This had the potential to affect 55 of 55 residents who receive food from the kitchen.	F 0812	**What corrective action will be accomplished for those residents found to have been affected by the deficient**	07/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paige Metzler	Executive Director	06/25/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Findings include: A kitchen tour was conducted with the Culinary Manager (CM) on 6/10/25 at 9:12 a.m. The kitchen floors were dirty with food debris on the floor. The drain by the dishwasher contained corn, a plastic fork, and a grey looking food substance within the drain. There was dust caked on the walls, ceiling, and on a metal shelf right above the serving table within the kitchen. The CM indicated that a cleaning schedule was just initiated on 6/9/25. An observation of the kitchen was conducted on 6/10/25 at 12:02 p.m. The drain remained the same along with the dust located on the metal shelf. The kitchen floors appeared sticky. During an interview with the Executive Director (ED) on 6/10/25 at 1:13 p.m., she indicated there were no policies regarding the cleanliness of the kitchen. The expectations were for the facility to follow the guidelines. This deficiency was cited on 4/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-21(i)(2) 3.1-21(i)(3)		**practice?** Floors were scrubbed and swept free of debris. Corn, plastic fork, and food substance were removed from the drain by the dishwasher. Walls and ceiling were cleaned and painted. Dust was removed from the metal shelf. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Directed inservice training completed on 6/27/2025 to ensure training is conducted on cleaning the kitchen and implementing a cleaning schedule for staff to follow. Deep cleaning of the kitchen completed by 7/2/2025. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Directed inservice training will be completed on 6/27/2025 to ensure training is conducted on cleaning the kitchen and implementing a cleaning schedule for staff to follow. Daily/weekly tasks were implemented on 6/12/2025 with revisions and finalization of these cleaning schedules on 6/19/2025. **How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur? ED/designee to complete sanitation weekly with RD/designee completing monthly. Items of concern will immediately be provided to CM for follow-up/review. CM to conduct daily walk-through checklist and to correct items and/or provide education as seen. If ASC benchmark of 85% is not achieved, an action plan will be developed to ensure compliance.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to provide a homelike environment for 3 of 5 residents reviewed for physical environment. (Resident 3, Resident H, and Resident 6) Findings include: An observation was conducted of Resident 3's room on 6/10/25 at 9:40 a.m. There were visible lines of missing paint along the wall and a hole in the covering for the call light box along the wall. An observation was conducted of Resident 6's room on 6/10/25 at 9:45 a.m. There was a tall and slim fan that contained dust on the side and front where the air was expelled. An observation was conducted of Resident H's room on 6/10/25 at 11:07 a.m. There was a large area of missing paint along the wall beside	F 0921	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident 3's room was touched up with paint and the hole in the covering for the call light box along the wall was repaired. Dust was removed from resident 6's fan Wall beside resident H's bed was touched up with paint. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Audit of rooms was completed to determine additional	07/02/2025

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	Resident H's bed. An observation was conducted of Resident 3 and Resident 6's room on 6/10/25 at 11:10 a.m. The same environmental concerns were noted regarding the missing paint, dust on the fan, and the hole in the covering for the call light box along the wall. An environmental tour was conducted with the Executive Director on 6/10/25 at 12:40 p.m. Resident 3's room remained with missing paint along the wall and the hole in the covering of the call light box. Resident 6's fan was still noted with dust and Resident H's room continued to have missing pain along the wall next to the bed. During an interview with the Executive Director on 6/10/25 at 1:13 p.m., she indicated there were no policies pertaining to a homelike environment. The expectations were for the facility to follow the guidelines. This deficiency was cited on 4/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(f)(5)		rooms that needed paint touch ups. Paint touch ups were completed for all identified rooms by 7.2.2025. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Managers to complete work orders for all rooms needing paint touch ups during daily rounds with copy being provided to Maintenance Supervisor. Maintenance Supervisor and Executive Director to conduct monthly rounds to review environment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** ED/designee to complete weekly rounds using Quality Control Enviromental Checklist. Items of concern will immediately be entered into TELS for completion. Weekly rounds will be completed for 4 weeks, monthly for 3 months, then per the QAPI calendar. Checklists will be reviewed monthly for trends – trends noted will require an action plan to be reviewed at QAPI.	