PRINTED: 06/25/2025 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES		OM	IB NO. 0938-039			
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST					
COMMU	NITY NURSING AN	D REHABILITATION CENTER		INDIAN	NAPOLIS, IN 46218			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
E 0000								
Bldg	conducted by the In accordance with 42 Survey Date: 05/20 Facility Number: 0 Provider Number: 100 At this Emergency Community Nursing was found in complement of the preparedness Required Medicaid Participat CFR 483.73. The facility has 115 the survey, the censility accordance with 42 The facility has 115 the survey, the censility accordance with 42 The facility has 115 the survey, the censility accordance with 42 Survey Date: 05/20 Facility Number: 05/20 Facility Number: 05/20 At this Emergency 10/20 Community Nursing was found in complete the com	0/25 00012 155029 274900 Preparedness survey, g and Rehabilitation Center iance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 55.	E 04	000	The Facility offers its respondence allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. Facility formally requests a desk review of the following plans of correction.	The		
K 0000	Quality Review con	npleted on 05/28/25						
K 0000								
Bldg. 01	Licensure Survey w	00012 155029	K 0	000	The Facility offers its respondence allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. Facility formally requests a desk review of the following plans of correction.	The		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

At this Life Safety Code survey, Community

TITLE

(X6) DATE

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	01	COMPL	ETED
		155029	B. WING	G		05/20/	/2025
			' 	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			16TH ST		
COMMU	NITY NURSING AN	ID REHABILITATION CENTER			APOLIS, IN 46218		
		IS REINSEIN TION SERVICE	, 1		74 0210, 114 10210		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ilitation Center was found not					
	-	Requirements for Participation					
		aid, 42 CFR Subpart 483.90(a),					
		re and the 2012 Edition of the					
		ction Association (NFPA) 101,					
		LSC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	This true stame facil	ity was determined to be of					
		ruction and fully sprinklered.					
		re alarm system with smoke					
		ridors and in all areas open to					
		acility has battery operated					
		stalled in resident sleeping					
		141 and 233 through 237. The					
	_	detectors hard wired to the fire					
	•	led in all other resident					
	-	ne facility has a capacity of 115					
		55 at the time of this visit.					
	and had a census of	33 at the time of this visit.					
	All areas where resi	idents have customary access					
		All areas providing facility					
	-	klered except for two detached					
	-	g facility storage services					
	which are each not						
	Quality Review cor	npleted on 05/28/25					
		•					
K 0211	NFPA 101						
SS=F	Means of Egress	- General					
Bldg. 01							
	Based on observation	on and interview, the facility	K 021	1	What corrective action will be		06/20/2025
	failed to ensure all	means of egress were			accomplished for those reside	nts	
	-	ained free of all obstructions			found to have been affected by	y the	
	-	full instant use in the case of			deficient practice?		
		ency. This deficient practice			Items stored outside of Room	232	
		dents, staff and visitors if			corridor were removed. cart		
	needing to exit the	facility.			outside Room 139 and 212 wa	as	
					replaced with wheeled . chair	was	
	Findings include:				removed outside of Room 141	in	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2025	
	PROVIDER OR SUPPLIEI NITY NURSING AN	R ND REHABILITATION CENTER		5600 E	ADDRESS, CITY, STATE, ZIP COD 16TH ST IAPOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
140	Based on observation Maintenance Direct a. at 12:29 p.m., that type buffet food care outside resident slee floor. The items preight foot wide comb. at 12:39 p.m., a process of the second floor. The wheeled and project wide corridor. c. at 1:43 p.m., a widrawers and a plast drawers for isolation corridor outside resident floor whice eight foot wide corridor outside resident first floor whice eight foot wide combelled or affixed d. at 1:44 p.m., a win front of the north facility on the first Room 141 on the first Room 141 on the first at 1:51 p.m., a choutside resident slee floor which project foot wide corridor. The floor or to the wide aforementioned was not continually obstructions or imput the case of fire or or These findings were	ons on 05/20/25 with the tor, the following was noted: the mattress and old wheeled art were stored in the corridor eping Room 232 on the second rojected over two feet into the ridor. The clastic three drawer chest of the supplies was stored in the dident sleeping Room 212 on the chest of drawers was not sted one foot into the eight foot the dident sleeping Room 139 on the projected 20 inches into the ridor. Neither item was to the floor or to the wall. The chair was placed directly the exit door to the outside of the floor by resident sleeping from 124 on the first ed twenty inches into the eight. The chair was not affixed to wall. The chair was not affixed to wall.			front of exit door. outside of F124 corridor was removed. In the and what corrective action will be taken? All residents had the potential to be affected by alleged deficient practice. The maintenance director or will conduct rounds to ensure that corridors are free from items. issues will be immediately rectified. What measures will be put into place and what systemic changes will be mattoned ensure the deficient practice. Was through to ensure the deficient practice of the compliance. Executive director compliance. Executive director to ensure the deficient practice will not recur and what qualical assurance program will be printo place? Maintenance director or designee will do a weekly through for six months to ensure the deficient practice. If a threshold 100% is not met, an action plawill be developed to ensure compliance. Executive director compliance.	low n ave the Any l ade ice r to ed ice ty ut ctor walk ure ht to I of	DATE
	exit conference.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		r í	JILDING	onstruction <u>0</u> 1	(X3) DATE SURVEY COMPLETED 05/20/2025		
	PROVIDER OR SUPPLIEI	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-19(b)						
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01							
	Based on observati	on and interview, the facility	K 0	222	What corrective action will be		06/20/2025
	failed to ensure the	means of egress through 1 of			accomplished for those reside	nts	
		the second floor were readily			found to have been affected b	y the	
		ents without a clinical			deficient practice?		
		specialized security measures.			The facility will post codes to		
	-	aired means of egress shall not			doors in an obvious fashion at		
		latch or lock that requires the			exit door located on the secon	ıd	
		from the egress side unless			floor. How be and what		
	_	d by LSC Section 19.2.2.2.4.			corrective action will be		
	_	gements shall be permitted in 2.2.2.5.2. This deficient			taken? All residents with acce		
		et over 10 residents, staff and			to exit doors have the potentia	II IO	
	^	to exit the facility from the			be affected by the deficient practice. The code is now pos	tod	
	second floor.	o exit the facility from the			at the exit door in an obvious	leu	
	second floor.				fashion. The maintenance dire	ector -	
	Findings include:				or will conduct rounds to ensu that codes are posted. Any iss	ire	
	Based on observation	ons with the Maintenance			will be immediately	iucs	
		.m. on 05/20/25, the stairwell exit			rectified. What measures wil	1	
	_	eeping Room 232 on the			be put into place and what	•	
	-	arked as a facility exit with an			systemic changes will be ma	ade	
	exit sign. The door	could be opened by entering a			to ensure the deficient pract		
	four digit code at a	keypad by the exit door but			does not recur? Maintenance		
	the correct code to	open the door was not posted.			director or designee will do a	ın	
	The Maintenance D	Director stated the posted code			audit of the facility monthly to		
		ried several times to either			ensure that codes are posted	in	
		de or reset the keypad with a			an obvious fashion. Any issue	:S	
		intenance Director was able to			will be immediately rectified.		
		th a new code and the door			director or will do a monthly w		
		to open after the code was			through to ensure compliance		
		erview at 12:36 p.m. on			Executive director to		
		tenance Director agreed the			compliance. How be monitor		
		been posted at the stairwell			to ensure the deficient pract		
1	exit door.				will not recur and what quali	۲V	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155029	B. W	ING		05/20/	/2025
	PROVIDER OR SUPPLIER	ID REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDERS BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	_	e reviewed with the Executive aintenance Director during the			assurance program will be p into place? Maintenance director designee will do a monthly through for six months to ensure compliance with results broug QAPI for review. If a threshold 100% is not met, an action plawill be developed to ensure compliance. Executive director compliance.	ctor walk ure ht to I of an	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Sm	nokeproof Enclosures					
	failed to ensure item escape stairways we LSC 7.2.2.5.3.1 state enclosure shall not has the potential to deficient practice of and visitors using the floor by the elevator in the first floor by the elevator in the first floor by facility exit with an broom, a dust pan, a electrical tool were first floor which we based on interview Maintenance Direct stairwell on the first which could interfeitems from the stair	ons with the Maintenance n. on 05/20/25, the exit stairwell the elevator was marked as a exit sign. Two shelves, a an extension cord and an stored in the stairwell on the ould interfere with egress. at 1:36 p.m. on 05/20/25, the tor agreed the aforementioned t floor was used for storage re with egress and removed the	K 0	225	What corrective action will be accomplished for those reside found to have been affected by deficient practice? Items in the exit stairwell on the first floor by the elevator were removed. How be and what corrective action will be taken? All residents have the potential to affected by this deficient pract. The maintenance director or we conduct weekly rounds to ensure that corridors are free from ite. Any issues will be immediately rectified. What measures will be put into place and what systemic changes will be made to ensure the deficient practic does not recur? Maintenance director or designee a weekly through to ensure compliance. Executive director to compliance. How be monitored to ensure the deficient practic will not recur and what quality through to ensure the deficient practic will not recur and what quality.	y the b be ice. vill ure ms. y I ide ice walk . ed	06/20/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2025		
	PROVIDER OR SUPPLIER	ID REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Director and the Ma exit conference. 3.1-19(b)	aintenance Director during the			assurance program will be p into place? Maintenance director designee will do a monthly through for six months to ensure compliance with results brough QAPI for review. If a threshold 100% is not met, an action plawill be developed to ensure compliance. Executive director compliance.	etor walk are nt to of	
K 0291 SS=D Bldg. 01	NFPA 101 Emergency Lightin	ng					
	Based on record review, observation and interview; the facility failed to document monthly testing for 1 of 4 battery backup lights in the facility in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect over one staff		HR location emergency light fixture has been removed as it not required. How be and w corrective action will be taken? No residents have the potential to be affected by deficient practice. What measures will be put into pla and what systemic changes will be made to ensure the deficient practice does not recur? The maintenance director designee will remove emergency light. Executive director to compliance. How b monitored to ensure the deficient practice will not recand what quality assurance	y the is hat ce eur	06/20/2025		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2025		
	PROVIDER OR SUPPLIEI NITY NURSING AN	RID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION
TAG	Findings include: Based on review of Documentation "En Conduct a 90-minu documentation date Maintenance Directotal of four battery functional tested for 04/09/25 annual fur included an "HR" I Supply TELS Logb "Emergency and Emergency and E	ad 04/09/25 with the tor at 10:55 a.m. on 05/20/25, a backup lights were annually responsible of the netional testing documentation ocation. Review of Direct book Documentation wit Lighting: Conduct a lest documentation for the month period only listed a y backup lights were located in attery backup light locations did to location. Based on a.m. on 05/20/25, the tor stated he recently found ght location, it needs to be		TAG	compliance with results broug QAPI for review. If a threshold 100% is not met, an action ple will be developed to ensure compliance. Executive director compliance.	d of an	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155029	B. W	NG		05/20/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			16TH ST		
COMMUI	NITY NURSING AN	ID REHABILITATION CENTER		INDIANAPOLIS, IN 46218			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
K 0300	NFPA 101						
SS=C	Protection - Other						
Bldg. 01	D 1 1			200			06/00/000
		view, observation and	K 0	300	What corrective action will be		06/20/2025
		ty failed to ensure preventative			accomplished for those reside		
		battery operated smoke alarms			found to have been affected b	y the	
		vas performed. NFPA 101 in			deficient practice?		
		ring life safety features obvious			Cleaning of all battery-operate		
	_	required by the Code, shall be			smoke detectors, including roo		
		eficient practice could affect all			257 completed and document	ation	
	residents, staff and	VISITORS.			placed in TELS Logbook		
	Diadian in dad.				documentation.		
	Findings include:				How be and what corrective		
	D1	Direct Consults TELC Look of			action will be taken? All		
		Direct Supply TELS Logbook			residents have the potential to		
		etectors Test: battery operated ocumentation for the most			affected by this deficient pract	ice.	
		h period with the Maintenance			Maintenance director or will		
		m. on 05/20/25, battery operated			complete weekly testing and	-44	
		ning documentation was not			monthly cleaning battery opera		
		7. Based on interview at 11:30			smoke detectors. Maintenand		
		ne Maintenance Director stated			Director completed cleaning o smoke detectors. What	ı alı	
		battery operated smoke			measures will be put into pla		
	1	esident sleeping rooms on a			and what systemic changes	ICE	
		ing documentation might be in			will be made to ensure the		
	-	eaning documentation was not			deficient practice does not		
	_	at the time of the survey. At			recur? Maintenance director of	or	
		0/25, during a tour of the facility,			designee will add testing sche		
	_	umentation affixed to the			and a monthly cleaning sched		
		alled in resident sleeping			to system. will monitor	4.0	
		st the detector weekly and to			compliance.		
		nonthly. Based on interview at			How be monitored to ensure		
		0/25, the Maintenance Director			the deficient practice will not		
	^	e of battery operated smoke			recur and what quality	-	
		in each resident sleeping			assurance program will be p	ut	
		ot have a fire alarm system			into place? Maintenance dire		
	smoke detector inst	-			or designee will do a weekly		
					testing and monthly cleaning		
	These findings were	e reviewed with the Executive			QAPI for six months to ensure	,	
		aintenance Director during the			compliance with results broug	ht to	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2025		
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	DRRECTION (X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG			DATE
	exit conference. 3.1-19(b)				QAPI for review. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. Executive director to compliance.		
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings	- Enclosure					
	failed to maintain processially stairwells. LSC 19. shall be enclosed or Section 8.6. LSC 8 separates stories in a constructed as a smooth states the separation fire resistance rating stories or less. This over 10 residents, stafloor. Findings include: Based on observation Director at 12:15 p. mechanism on the second floor door frame which could be a constructed or frame and constructed	on and interview, the facility rotection of 1 of 3 interior 3.1 requires vertical openings protected in accordance with .6.1 requires every floor that a building shall be oke barrier. LSC 8.6.5 states closures of exits. LSC 7.1.3.2.1 a shall have a minimum 1-hr g where the exit connects three deficient practice could affect that and visitors on the second ons with the Maintenance m. on 05/20/25, the latching tairwell door by the elevator would not protrude into the aused the stairwell door to not frame when tested to close estairwell door was equipped be resistance rating label affixed the door. Based on interview would not maintain the fire the stairwell vertical opening.	K 0.	311	What corrective action will be accomplished for those reside found to have been affected by deficient practice? The latching mechanism on the stairwell door by the elevator of the second floor was fixed to the second floor will be taken? All residents have the potential to be affected by this deficient practice. director or we complete weekly rounds to enlatches on door work properly. The measures will be put into plate and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance director of designee will complete weekly rounds to ensure the deficient practice will not recur and what quality assurance program will be printo place? Maintenance director designee will do a weekly we through for door latches on door latches latche	y the e on he vill sure will nce or y ooor red ice ty ut ctor valk	06/20/2025
	These findings were	e reviewed with the Executive			for six months to ensure	.OI	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		(X2) MULTIPLE A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 05/20/2025	
СОММИ	PROVIDER OR SUPPLIER	D REHABILITATION CENTER	5600	ET ADDRESS, CITY, STATE, ZIP COD LE 16TH ST ANAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Director and the Ma exit conference. 3.1-19(b)	nintenance Director during the		compliance with results broug QAPI for review. If a threshol 100% is not met, an action pl will be developed to ensure compliance. Executive direct compliance.	d of lan
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System -	- Installation			
Blug. U I	failed to ensure the heads were not obst Activities Offices in NFPA 13, 2010 edit sprinklers shall be leads to obstructions to discipate the hazard. Sections shall be provided to the hazard. Sections permit continuous of less than or equal to deflector or in a hor inches below the spray pattern frodeficient practice of staff and visitors in Office on the second Findings include:	on and interview, the facility spray pattern for sprinkler ructed in 1 of 1 second floor a accordance with LSC 19.3.5.1. tion, Section 8.5.5.1 states ocated so as to minimize harge as defined in Section 8.5.5.3 or additional sprinklers ensure adequate coverage of a 8.5.5.2 and 8.5.5.3 do not or noncontinuous obstructions of 18 inches below the sprinkler rizontal plane more than 18 rinkler deflector that prevent om fully developing. This ould affect over ten residents, the vicinity of the Activities d floor.	K 0351	What corrective action will be accomplished for those resid found to have been affected deficient practice? Director removed curtain bloc sprinkler coverage. How be what corrective action will be taken? All residents have the potential to be affected by this deficient practice. Maintenan director or removed curtains staff educated. What measus will be put into place and with systemic changes will be must be ensure the deficient practice. Maintenant director or designee will commonthly rounds to ensure spreadoes not recur? Maintenant director or designee will commonthly rounds to ensure spreadoes are not blocked. Will monitor compliance. How be monitored to ensure the deficient practice will not resident practice will not resident practice will not resident.	ents by the cking and be s s ce and ires hat ade tice e plete rinkler e
	Director at 12:44 p. no mesh was hung i of the second floor blocked the sprinkle in the closet. The c curtain was in place top of the curtain was	m. on 05/20/25, a curtain with n place across the closet area Activities Office which er spray pattern of the sprinkler loset did not have a door. The to cover the closet area. The as installed within six inches d on interview at 12:44 p.m.,		and what quality assurance program will be put into place? Maintenance director designee will do a monthly th to ensure sprinklers are not blocked for six months to ensure sprinklers are not blocked for six months to ensure with results broug QAPI for review. If a threshol	or rough sure ght to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2025		
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		5600 E	ADDRESS, CITY, STATE, ZIP COD 16TH ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	would obstruct the sand removed the cu These findings were	rector agreed the curtain sprinkler coverage in the room rtain. e reviewed with the Executive sintenance Director during the			100% is not met, an action pla will be developed to ensure compliance. Executive directo compliance.		
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System	· Maintenance and Testing					
	failed to ensure 1 of visitor's restrooms be the first floor lobby replaced in accordar Standard for the Ins Maintenance of Wa Systems, 2011 Editis sprinklers shall not be free of corrosion physical damage; are correct orientation (sidewall). Furtherm that shows signs of replaced: (1) Leakage (2) Corrosion (3) Physical Damag (4) Loss of fluid in element (5) Loading (6) Painting unless paramufacturer. In lieu of replacing dust, it is permitted	che glass bulb heat responsive bainted by the sprinkler sprinklers that are loaded with to clean sprinklers with y a vacuum provided that the	K 0	353	What corrective action will be accomplished for those reside found to have been affected by deficient practice? Maintenance director or contal IEI regarding replacement. He be and what corrective action will be taken? All residents has the potential to be affected by deficient practice, director or contacted IEI for replacement, sprinkler heads were checked ensure the integrity of the sprinkad by the maintenance director What measures will be put into place and what systemic changes will be mate to ensure the deficient practice does not recur? Maintenance director or designee will comp monthly rounds to ensure sprinkeds are free of rust, will more compliance. How be monito to ensure the deficient practice will not recur and what qualications are program will be put into place? Maintenance directors or designee will be put into place? Maintenance director or designee will be put into place? Maintenance director or designee will be put into place? Maintenance director place?	y the cted low n ave this All to nkler e lete nkler nitor red ice ty ut	06/20/2025

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/20/2025 155029 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5600 E 16TH ST COMMUNITY NURSING AND REHABILITATION CENTER INDIANAPOLIS, IN 46218 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE This deficient practice could affect over five or designee will do a monthly residents in the vicinity of the first floor main through to ensure sprinkler heads entrance lobby. are free of rust for six months to ensure compliance with results Findings include: brought to QAPI for review. If a threshold of 100% is not met, an Based on observations with the Maintenance action plan will be developed to Director at 1:02 p.m. on 05/20/25, the ceiling ensure compliance. Executive mounted sprinkler located in the visitor's restroom director to compliance. directly behind the reception desk in the main entrance lobby on the first floor was covered with rust. Based on interview at 1:02 p.m. on 05/20/25, the Maintenance Director agreed the aforementioned sprinkler location was loaded with rust. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) K 0361 **NFPA 101** SS=E Corridors - Areas Open to Corridor Bldg. 01 Based on observation and interview, the facility K 0361 What corrective action will be 06/20/2025 failed to ensure 1 of 1 therapy rooms were accomplished for those residents separated from the corridor by a partition capable found to have been affected by the of resisting the passage of smoke as required in a deficient practice? sprinklered building, or met an Exception per Maintenance director or will 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces contact to replace lock How be other than patient sleeping rooms, treatment and what corrective action will rooms, and hazardous areas shall be open to the be taken? All residents have the corridor and unlimited in area, provided: (a) The potential to be affected by this space and corridors which the space opens onto deficiency practice. Maintenance in the same smoke compartment are protected by director or will contact ADA an electrically supervised automatic smoke . What measures will be put detection system in accordance with 19.3.4, and into place and what systemic

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(b) Each space is protected by an automatic

sprinklers, and (c) The space does not to obstruct

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changes will be made to

ensure the deficient practice

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/20/2025	
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER	5600 E	ADDRESS, CITY, STATE, ZIP COD 1 16TH ST NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0302	could affect over fivin the vicinity of the floor. Findings include: Based on observation Director at 12:50 p. door to the Therapy lobby on the first floop sitive latching me the door frame. The thumb twist locking to lock or unlock the door. The door frame unless it was 12:50 p.m. on 05/20 agreed the corridor was not equipped we to secure the door in ensure the treatmen corridor. These findings were Director and the Malexit conference. 3.1-19(b)	xits. This deficient practice we residents, staff and visitors at Therapy Room on the first ons with the Maintenance on 05/20/25, the corridor Room near the main entrance or was not equipped with a echanism to latch the door into the door was equipped with a device which required a key the door from the corridor side of would not latch into the door locked. Based on interview at 10/25, the Maintenance Director door to the Therapy Room with a positive latching device that the door frame and to the door frame and to the reviewed with the Executive anintenance Director during the		does not recur? Maintenance director will complete a 1x audensure all locks are within code. How be monitored to ensure the deficient practice will not recur and what quality assurance program will be printo place? Maintenance directly or designee will do a monthly through to ensure locks within facility are within code for six months to ensure compliance results brought to QAPI for reliff a threshold of 100% is not in an action plan will be developensure compliance. Executive director to compliance.	dit to e e e e e e e e e e e e e e e e e e
K 0362 SS=E Bldg. 01	failed to ensure corr compartments on th to resist the transfer practice could affect	on and interview, the facility ridor walls in 1 of 7 smoke the first floor were constructed to f smoke. This deficient to over 10 residents, staff and the off mechanical room by	K 0362	What corrective action will be accomplished for those reside found to have been affected be deficient practice? The HVAC unit was repaired ensure it was flush with the gr	ents by the

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resident sleeping Room 131 on the first floor.

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opening in the door How be and

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155029		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/20/2025				
	ROVIDER OR SUPPLIEF	ID REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 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	(X5) COMPLETION DATE				
	Director at 1:42 p.n inch grill was instal corridor door to the sleeping Room 131 meant to be a return mechanical room be the grill and would smoke. Based on in 05/20/25, the Maint HVAC return was rein the door and worsmoke. These findings were	ons with the Maintenance h. on 05/20/25, a 16 inch by 16 led in the bottom of the mechanical room by resident on the first floor. The grill was h for HVAC equipment in the at the return was not flush with not resist the transfer of hterview at 1:42 p.m. on henance Director agreed the hot flush with the grill opening hald not resist the passage of he reviewed with the Executive haintenance Director during the		what corrective action will be taken? All residents have the potential to be affected by this deficiency practice. All corrid walls were inspected to ensure walls would resist the transfer smoke by the maintenance director What measures will be put into place and what systemic changes will be maintenance to ensure the deficient practice does not recur? Corridor walls will be inspected monthly to ensure there is not transfer of smoke by the maintenance director. How be monitored to ensure the deficient practice will not recur and what quality assurance program will be pure into place? Maintenance director designee a monthly inspector of corridor to ensure there is no poportunity of transfer of smowithin the facility for six month ensure compliance with result brought to QAPI for review. If threshold of 90% is not met, a action plan will be developed ensure compliance. Executive	soor ree of II ade ice t t t t t st st st st st st			
K 0374 SS=E Bldg. 01	Based on observation failed to ensure 1 or on the first floor wo	on and interview, the facility f 4 sets of smoke barrier doors buld restrict the movement of minutes. LSC 19.3.7.8	K 0374	director to monitor for compliance. What corrective action will be accomplished for those reside found to have been affected by deficient practice?	ents			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/20/2025				
	NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218					
COMMUI (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR requires doors in sm LSC Section 8.5.4. smoke barrier shall the minimum cleara operation. This def over 20 residents, st of the smoke barrier Room 115 on the fin Findings include: Based on observation Director at 1:37 p.m. corridor door set by on the first floor wa coordinator installed door set failed to fu gap in between the su when tested to close closing coordinator Each door in the do open position with so open devices set to activation and was of devices. Based on in 05/20/25, the Maint cross corridor door 115 on the first floo because the door cle function properly.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION noke barriers shall comply with LSC 8.5.4.1 requires doors in close the opening leaving only nnce necessary for proper icient practice could affect raff and visitors in the vicinity r door set by resident sleeping	II PRE)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Maintenance director or desig adjusted door coordinator Roo 115. How be and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. director or or complete walk through to ensi- coordinator is working properly. All cross coordinator door sets were checked to ensi- proper closure by the mainten director. What measures will put into place and what systemic changes will be ma to ensure the deficient practic does not recur? Maintenance director or designee will comp walk through to ensure coordin is working properly. How be monitored to ensure the deficient practice will not rec and what quality assurance program will be put into place? Maintenance director or will do a weekly through to ensure coordinator within the fact within code for six months to ensure compliance with result brought to QAPI for review. If a threshold of 100% is not met, action plan will be developed to	mee om will ure r sure ance be de ce clete nator cur or sure sility s a an	(X5) COMPLETION DATE		
K 0712 SS=C Bldg. 01	Director and the Ma exit conference. 3.1-19(b) NFPA 101 Fire Drills	uintenance Director during the			ensure compliance. Executive director to compliance.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u>			COMPLETED	
		155029	B. WING 05/20/2025			/2025		
				CTREET	ADDRESS SITU STATE ZIR SOD			
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
COMMUNITY NUIDOING AND DELIADULITATION CENTED					16TH ST			
COMMUNITY NURSING AND REHABILITATION CENTER				INDIAN	IAPOLIS, IN 46218			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	Based on record review and interview, the facility		K 0	712	What corrective action will be		06/20/2025	
	failed to conduct qu	uarterly fire drills at unexpected			accomplished for those reside	ents		
	times under varying	g conditions on the third shift			found to have been affected b	y the		
	for four of four cale	endar quarters. This deficient			deficient practice?			
	practice could affect	ct all residents, staff and			Maintenance director will com	plete		
	visitors in the facili	ity.			a fire drill on 5/30/2025 at 4:00)		
					How be and what corrective	e		
	Findings include:				action will be taken? All			
					residents have the potential to	be		
	Based on review of	f Direct Supply TELs Logbook			affected by this deficient pract	ice.		
	Documentation "Fi	re Drills" with the Maintenance			Maintenance director or desig	nee		
	Director at 11:30 a	.m. on 05/20/25, ten of twelve			will complete schedule in TEL	S to		
	third shift fire drills	s were conducted at 6:00 a.m.			ensure fire are at unexpected			
	Documentation for	the following ten third shift fire			times on third shift. What			
	drills conducted wi	thin the most recent twelve			measures will be put into pla	ice		
	month period on 05	5/21/24, 06/21/24, 07/31/24,			and what systemic changes			
	09/24/24, 10/28/24	, 12/31/24, 01/31/25, 02/27/25,			will be made to ensure the			
	03/25/25 and on 04	30/25 indicated the fire drill			deficient practice does not			
	was conducted at 6	:00 a.m. In addition, the third			recur? Maintenance director of	or		
	shift fire drill on 08	3/31/24 was conducted at 5:30			will complete in TELS. Sched	ule		
	a.m. and the third s	hift fire drill on 11/26/24 was			will be reviewed by ED to ens	ure		
		a.m Based on interview at			fire drills are conducted at diff	erent		
		0/25, the Maintenance Director			times on third shift How be			
	1	perates three shifts per day,			monitored to ensure the			
		ft fire drill documentation			deficient practice will not red	cur		
		ent twelve month period was			and what quality assurance			
		view and agreed the			program will be put into			
		rd shift fire drills were not			place? Maintenance director	or		
	_	sected times under varying			will do a monthly through to			
	conditions.				ensure fire drills are complete			
					six months to ensure complian			
		re reviewed with the Executive			with results brought to QAPI for			
		aintenance Director during the			review. If a threshold of 100%			
	exit conference.				not met, an action plan will be			
	21100				developed to ensure compliar			
	3.1-19(b)				Executive director to compliar	ice.		
	3.1-51(c)							
V 0764	NEDA 404							
K 0761	NFPA 101	· 0.T · 5						
SS=E	Maintenance, Ins	pection & Testing - Doors			1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155029		A. Bl	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted 2025	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
COMMUI	COMMUNITY NURSING AND REHABILITATION CENTER				16TH ST IAPOLIS, IN 46218		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Based on record revinterview; the facility operation was maintifire doors in accordance requires any device, condition, arrangement other feature is required provision of this Cosystem, condition, a protection, or other maintained unless the maintenance. NFP and Other Opening Section 11.4.1.1 required evice shall be instant door. Section 11.4. shall close automatic release of a fusible 11.4.2.2.1 states that activated, the door sposition until the autoen reset. This definition is according to the facility of the facility	view, observation and ty failed to ensure proper tained for 1 of 1 rolling steel ance with NFPA 80. LSC 4.5.8 requipment, system, ment, level of protection, or any sired for compliance with the ode, such device, equipment, arrangement, level of feature shall thereafter be the Code exempts such A 80, Standard for Fire Doors Protectives, 2010 Edition, quires an automatic-closing steel 1.2 states rolling steel doors cally upon activation or link or detector. Section at after the automatic closing is shall remain in the closed attomatic-closing device has ficient practice could affect taff and visitors in the dining	K 0	761	What corrective action will be accomplished for those reside found to have been affected by deficient practice? Maintenance Director placed for rolling door on 6/11/2025. Waiver request submitted due parts for repair/replacement or rollup door are not in stock an need to be ordered by the vendor. How be and what corrective action will be taken? All residents have the potential to be affected by deficient practice. Maintenance Director placed order for rollind door on 6/11/2025. What measures will be put into pla and what systemic changes will be made to ensure the deficient practice does not recur? Additional safety measures to compensate for deficiency during waiver period additional fire drills. Once replaced, Maintenance directors	ents by the order e to if the id	09/15/2025
	Based on review of the rolling fire door inspection contractor's "Fire Door Drop Test" documentation dated 09/11/24 with the Maintenance Director at				will test rolling door 3x a montensure working properly durin drill on TELS. How be monitored to ensure the	th to	
	10:58 a.m. on 05/20	0/25, the rolling fire door in the			deficient practice will not re	cur	
		s having "no reported			and what quality assurance		
		d on review of the "Remarks"			program will be put into		
		ipply TELS Logbook			place? Maintenance director		
		re Drills" documentation dated			designee will do a monthly wa		
		y is "waiting on roll down door			through to ensure rolling door		
	_	interview at 10:58 a.m. on			working properly during fire di	rills	
	*	enance Director stated the			for six months to ensure		
	round tire door in t	ne kuchen does not operate			L COMPUSION WITH RESULTS BYOUR	IDIT TO	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE				
		155029	B. WING 05/20/2025				
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	automatically, an ol which may not be a replace the door. To stated documentation or replacement was Based on observation Director at 12:59 put fire door between the Room on the first fl. 90-minute fire resist door. The main Director and the Market conference. 3.1-19(b) NFPA 101 Electrical Systems Based on record revinterview; the facility written record of magenerator starting be months of the most accordance with NF 2012 NFPA 99 requigenerators shall be and Standby Power 8.3.7.1 states the magnetic based on the starting of electron conductance testing the testing of specific warranted. This definition is started to the starting of specific warranted. This definition is started to the starting of specific warranted. This definition is started to the starting of specific warranted. This definition is started to the starting of specific warranted. This definition is started to the starting of specific warranted. This definition is started to the starting of specific warranted. This definition is started to the starting of the starting	der part needs replacement vailable, and they may have to he Maintenance Director on for the status of the repair not available for review. Ons with the Maintenance on 05/20/25, the metal rolling he kitchen and main Dining oor was equipped with a tance rating label affixed to the ning Room on the first floor corridor. The reviewed with the Executive nintenance Director during the sintenance Director during the nintenance of emergency natteries was maintained for 11 recent 12 month period in PA 99. Chapter 6-4.4.1.3 of hires batteries for on-site maintained in accordance with dition, Standard for Emergency Systems. NFPA 110, Section nintenance of lead-acid de the monthly testing and lyte specific gravity. Battery shall be permitted in lieu of ficient practice could affect all	K 09		QAPI for review. Additional fire drills during waiver period will brought to QAPI meeting bi-monthly for review. If a three of 100% is not met, an action will be developed to ensure compliance. Executive director monitor for compliance What corrective action will be accomplished for those reside found to have been affected by deficient practice? Maintenance director will perfor a conductivity test on the batte to the generator. How be and what corrective action will be taken? Maintenance director will perform a conductivity test on battery to the generator. What measures will be put into plate and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance Director was a conductive to the generator. What measures will be made to ensure the deficient practice does not recur? Maintenance Director was a conductive to the generator.	shold plan r to	06/20/2025
	residents, staff and	V151tO15.			perform a conductivity test monthly and document in FD) will	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	01	COMPLETED		
		155029	B. W	B. WING 05/20/202			2025
						<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
COMMU	NUTY NU IDOING AN	ID DELIABILITATION CENTED			16TH ST		
COMMO	NITY NURSING AI	ND REHABILITATION CENTER		INDIAN	IAPOLIS, IN 46218		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				ensure the monthly conductiv	ity	
					test is completed monthly by		
		f the generator inspection			reviewing . How be monitore	d to	
	_	ction Report" documentation			ensure the deficient practice	;	
		h the Maintenance Director at			will not recur and what qual	_	
		0/25, the results of emergency			assurance program will be p	ut	
	-	pattery electrolyte testing was			into place?		
		Review of Direct Supply TELS			Maintenance director or design	jnee	
	-	ntation "Emergency Generators:			with conduct a monthly		
	_	er load" documentation dated			conductivity test for to ensure		
		a" in response to "Battery			compliance with results broug	•	
		and "Battery Conductance			QAPI for review. If a threshold		
		terview at 10:58 a.m. on			100% is not met, an action pla	an	
	· ·	tenance Director stated			will be developed to ensure		
	_	cy generator starting battery			compliance. Executive director	or to	
		ion for the most recent twelve			monitor for compliance		
	-	not available for review and					
		contractor performs battery					
		or conductance testing. Based					
		th the Maintenance Director at					
	_	/25, the facility has one					
		nergency generator located					
		g on the west side of the					
	property. Manufac	-					
	was rated at 200 kV	xed to the generator indicated it					
	was rated at 200 K	vv.					
	Those findings was	re reviewed with the Executive					
		aintenance Director during the					
	exit conference.	amenance Director during the					
	exit conference.						
	3.1-19(b)						
	3.1-17(0)						
K 0920	NFPA 101						
SS=E		ent - Power Cords and					
Bldg. 01	Extens	, 51.5. 55. 35 and					
		view, observation and	K 0	920	What corrective action will be		06/20/2025
		ity failed to ensure 1 of 1		, 20	accomplished for those reside		00,20,2023
		ere not used as a substitute for			found to have been affected by		
		f 1 first floor dining rooms. LSC			deficient practice?	,	

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82H521

Facility ID: 000012

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2025 FORM APPROVED OMB NO. 0938-039

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155029		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2025			
	NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218					
(X4) I PREF	TIX G	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
IA		19.5.1 requires utility LSC 9.1.2 requires of the comply with NFP 2011 Edition. NFP 2011 Edition of a structure of the safety shall be approved in accordance of the safety shall be approved in accordance of the safety shall be approved in accordance accordance of the safety shall be approved in accordance of the Emergency Action of Preparedness Program 203/14/25 with the Emergency Action of Preparedness Program 203/14/25 with the Emergency Action of the use of extension wiring is prohibited observations with the 1:05 p.m. on 05/20/2 was plugged into a very above the cabin dining room on the was run above the safety above the safety extension cord was connected to a corner of the room. On 05/20/25, the an extension cord was for fixed wiring in full of these findings were	ties to comply with Section 9.1. Plectrical wiring and equipment PA 70, National Electrical Code, PA 70, Article 400.8 requires that, permitted, flexible cords and used as a substitute for fixed PLEC Section 4.5.7 states any pripment or safeguard provided pe designed, installed and punce with all applicable NFPA dicient practice could affect aff and visitors in the dining		IAU	Power cords removed from room. How be and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. What measures will be put into pla and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance director of will complete monthly work through to ensure power cords not used outside of code. How the deficient practice will not recand what quality assurance program will be put into place? Maintenance director of monthly through to ensure power cords are not used outside of six months to ensure compliar with results brought to QAPI for review. If a threshold of 100% not met, an action plan will be developed to ensure compliant Executive director to monitor for compliance	or s are wer for nce or is	DATE	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/25/2025 FORM APPROVED OMB NO. 0938-039

CENTERSTOR	ENTERS FOR MEDICARE &								
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED		
		155029	B. WING			05/20/2025			
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218						
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	CORRECTION			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		

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