

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

PRINTED: 12/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/05/2023
NAME OF PROVIDER OR SUPPLIER CREEKSIDE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3114 EAST 46TH STREET INDIANAPOLIS, IN 46205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00423107.</p> <p>This visit was in conjunction with a Recertification and State Licensure Survey, and the Investigations of Complaints IN00421422 and IN00411851.</p> <p>Complaint IN00423107 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00421422 - Federal/State deficiencies related to the allegations are cited at F565.</p> <p>Complaint IN00411851 - Federal/State deficiencies related to the allegations are cited at F550 and F684.</p> <p>Survey dates: November 28, 29, 30, December 1, 4, and 5, 2023</p> <p>Facility number: 009569 Provider number: 155628 AIM number: 200139920</p> <p>Census Bed Type: SNF/NF: 104 Total: 104</p> <p>Census Payor Type: Medicare: 1 Medicaid: 88 Other:15 Total: 104</p> <p>Creekside Health and Rehabilitation Center was</p>	F 000			

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

TITLE

(X6) DATE

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.

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F 000	Continued From page 1 found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00423107. Quality review completed on December 12, 2023	F 000			