STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING _____ B. WING _____	R-C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	**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}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00355300 completed on June 16, 2021. This visit was in conjunction with the PSR to the Investigation of Complaints IN00358018, IN00357280, and IN00357157 completed on July 15, 2021 This visit was in conjunction with a PSR to the Recertification and State Licensure Survey. This visit included a PSR to the Investigation of Complaints IN00351254, IN00351434 and IN00353741 completed on May 19, 2021. Complaint IN00355300-Corrected. Complaint IN00358018-Corrected Complaint IN00357280-Corrected Complaint IN00357157-Corrected Complaint IN00351254-Corrected Complaint IN00351434-Corrected Complaint IN00353741-Corrected Survey dates: August 5 and 6, 2021 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 7 Medicaid: 79 Other: 7	{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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING _____ B. WING _____	R-C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	**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}	Continued From page 1 Total: Creekside Health and Rehabilitation was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00355300. Quality review completed on August 9, 2021	{F 000}		