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	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREEKSIDE HEALTH AND REHABILITATION CENTER	3114 EAST 46TH STREET INDIANAPOLIS, IN 46205

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/19/22 Facility Number: 009569 Provider Number: 155628 AIM Number: 200139920 At this Emergency Preparedness survey, Creekside Health and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 120 certified beds. At the time of the survey, the census was 113. Quality Review completed on 09/22/22	E 0000	**We hereby respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a Post Survey Revisit. All necessary corrections have been completed by 9/28/2022 as we hereby allege compliance as of that date. We are willing to submit any and all supporting documentation as requested to assure our credible compliance with the deficiencies noted in the CMS form 2567. We are providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth, effects, alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.**	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	K 0000	**We hereby respectfully requesting this agency consider paper compliance for**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	483.90(a). Survey Date: 09/19/22 Facility Number: 009569 Provider Number: 155628 AIM Number: 200139920 At this Life Safety Code survey, Creekside Health and Rehabilitation Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 113 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for a single detached storage garage that was unsprinklered. Quality Review completed on 09/22/22		**the following plan of correction as opposed to a Post Survey Revisit. All necessary corrections have been completed by 9/28/2022 as we hereby allege compliance as of that date. We are willing to submit any and all supporting documentation as requested to assure our credible compliance with the deficiencies noted in the CMS form 2567. We are providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth, effects, alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.**	
K 0223 SS=D Bldg. 02	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing			

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	and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: *Required manual fire alarm system; and *Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and *Automatic sprinkler system, if installed; and *Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen dry storage doors to a hazardous area enclosure was self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect staff in kitchen. Findings include: Based on observation during a tour of the facility with the Director of Plant Operations on 09/19/22 at 1:39 p.m., the dry storage room in the kitchen was over 50 square feet in size, containing large amounts of combustible supplies, and was provided with a door with self-closing device; but the door was held open by a rubber and wooden wedge under the door. The door being propped open would prevent the door from self-closing upon activation of the fire alarm. Based on interview at the time of observation, the Director of Plant Operations agreed the door to kitchen dry storage contained combustible storage, was greater the 50 square feet, and the door was held open with wedges on the floor. The wedges were removed and the door self-closed into the frame. This finding was reviewed with the Administrator	K 0223	**1. No residents were negatively affected. The wedge under the door in the dry storage room in the kitchen was immediately removed. All kitchen staff were in-serviced on doors with self-closing devices.** **2. All residents have the potential to be affected. All other doors in the facility have been inspected for wedges to prop open doors with no other findings completed.** **3. Kitchen staff will be educated on this requirement. All doors in the kitchen will be inspected weekly for 6 weeks and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained to**	09/28/2022

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	and Director of Plant Operations at the time of exit. 3.1-19(b)		**ensure doors are not propped.** **4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.**	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. Based on observation and interview, the facility	K 0363	**1. No residents were**	09/28/2022

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	failed to ensure 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 15 residents, staff and visitors in the 200 Hall. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility from 1:30 p.m. to 3:00 p.m. on 09/19/22, the door to resident room 229 was held open by a handheld dumbell weight placed in front of the door. Based on interview at the time of the observation, the Director of Plant Operations agreed the aforementioned corridor door was propped in the fully open position with a handheld weight placed on the floor. This finding was reviewed with the Administrator and Director of Plant Operations at the time of exit. 3.1-19(b)		**negatively affected. The dumbbell to prop open in the resident room door was immediately removed.** **2. All residents have the potential to be affected. A tour of the facility was completed and no other doors were found propped.** **3. Facility staff will be educated on this requirement, along with current residents. All facility doors will be inspected weekly for 6 weeks and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained to ensure they are not propped.** **4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.**	
K 0920 SS=B Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the			

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	patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure multiplug adapters were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 15 residents and staff in the 200 Hall. Findings include: During a tour of the facility with the Director of Plant Operations on 09/19/2022 from 1:30 p.m. to 3:00 p.m., a multi-plug adapter was found powering a Wi-Fi device and a motorized wheelchair charging powerpack in resident room 223. Based on interview at the time of observation, the Director of Plant Operations agreed that the multiplug adapter was being used to power electronics. The multiplug adapter was removed	K 0920	**1. No residents were negatively affected. The multiplug adapter in the resident room was immediately removed.** **2. All residents have the potential to be affected. All rooms in the facility have been inspected for multiplug adapters with no other findings.** **3. Staff will be educated on this requirement. Residents and families will be informed via leaflet and US Mail. All resident rooms will be inspected weekly for 6 weeks and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained to ensure no multiplug adapters**	09/28/2022

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	by the Director of Plant Operations at the time of observation. This finding was reviewed with the Administrator and Director of Plant Operations at the time of exit. 3.1-19(b)		**are in use.** 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	