PRINTED: 09/30/2022 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDIC.	AID SERVICES		OMB NO. 093			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			
	155628	B WING	00/10/2022			

	PROVIDER OR SUPPLIEI	REHABILITATION CENTER		3114 E	ADDRESS, CITY, STATE, ZIP COD AST 46TH STREET JAPOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42 Survey Date: 09/19 Facility Number: 0 Provider Number: AIM Number: 200 At this Emergency Creekside Health a found in compliance Preparedness Requ Medicaid Participat CFR 483.73. The facility has 120 the survey, the cens	9/22 009569 155628 0139920 Preparedness survey, nd Rehabilitation Center was be with Emergency irements for Medicare and ting Providers and Suppliers, 42 0 certified beds. At the time of	E 00	000	We hereby respectfully requesting this agency consider paper compliance the following plan of correas opposed to a Post Surv Revisit. All necessary corrections have been completed by 9/28/2022 as hereby allege compliance that date. We are willing to submit any and all support documentation as request assure our credible comp with the deficiencies note the CMS form 2567. We are providing our plan of correction. Submission of plan of correction does not constitute an admission of agreement by the provide the truth, effects, alleged corrections set forth on the statement of deficiencies. plan of correction is prepared and submitted because of requirements under state federal law. Please accept plan of correction as our credible allegation of compliance.	ection vey s we as of o ting ted to liance d in e this ot r an r of or lie The ared	
Bldg. 02	Licensure Survey v	e Recertification and State was conducted by the Indiana Ith in accordance with 42 CFR	K 0	000	We hereby respectfully requesting this agency consider paper compliance	e for	

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

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 093			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>	COMPLETED			
	155629	D WING	00/10/2022			

AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155628		1	A. BUILDING <u>02</u> B. WING		COMPLETED 09/19/2022		
	NAME OF PROVIDER OR SUPPLIER  CREEKSIDE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3114 EAST 46TH STREET INDIANAPOLIS, IN 46205				
CREEKS (X4) ID PREFIX TAG	SUMMARY SEARCH DEFICIEN REGULATORY OR 483.90(a).  Survey Date: 09/19  Facility Number: 0 Provider Number: AIM Number: 200  At this Life Safety Cand Rehabilitation Compliance with Removement Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L. Care Occupancies and This one-story facil Type V (111) constructions of the same spent of the codetectors hard wired areas open to the codetectors hard wired resident sleeping rook 19/19/19/19/19/19/19/19/19/19/19/19/19/1	222 29569 25628 26920 260de survey, Creekside Health Center was found not in equirements for Participation 42 CFR Subpart 483.90(a), re and the 2012 Edition of the etion Association (NFPA) 101, SC), Chapter 18, New Health	IENCIE  ID  PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  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		e of g to ce ce	(X5) COMPLETION DATE		
K 0223 SS=D Bldg. 02	All areas where resi were sprinklered an services were sprink detached storage ga  Quality Review con NFPA 101 Doors with Self-Cl Doors in an exit pa enclosure, or horiz	•			credible allegation of compliance.			

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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 02 B. WING 09/19/2022 155628 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3114 EAST 46TH STREET INDIANAPOLIS, IN 46205 CREEKSIDE HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 09/28/2022 Based on observation and interview, the facility K 0223 No residents were failed to ensure 1 of 1 kitchen dry storage doors to negatively affected. The wedge a hazardous area enclosure was self-closing and under the door in the dry kept in the closed position, unless held open by a storage room in the kitchen release device complying with 7.2.1.8.2. This was immediately removed. All deficient practice could affect staff in kitchen. kitchen staff were in-serviced on doors with self-closing Findings include: devices. Based on observation during a tour of the facility with the Director of Plant Operations on 09/19/22 All residents have the at 1:39 p.m., the dry storage room in the kitchen potential to be affected. All was over 50 square feet in size, containing large other doors in the facility have amounts of combustible supplies, and was been inspected for wedges to provided with a door with self-closing device; but prop open doors with no other the door was held open by a rubber and wooden findings completed. 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 3. Kitchen staff will be of Plant Operations agreed the door to kitchen dry educated on this requirement. storage contained combustible storage, was All doors in the kitchen will be greater the 50 square feet, and the door was held inspected weekly for 6 weeks open with wedges on the floor. The wedges were and until 100% compliance is

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removed and the door self-closed into the frame.

This finding was reviewed with the Administrator

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achieved, then monthly for 6 months and until 100%

compliance is maintained to

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

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AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155628	A. BU	) MULTIPLE CONSTRUCTION . BUILDING 02 . WING		(X3) DATE SURVEY COMPLETED 09/19/2022
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		3114 E	ADDRESS, CITY, STATE, ZIP COD AST 46TH STREET APOLIS, IN 46205	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	and Director of Plai 3.1-19(b)	nt Operations at the time of exit.			4. The findings of these audits will be presented dur the facility's monthly QAPI meetings and the plan of action adjusted accordingly	ing
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.		K 0'	363	1. No residents were	09/28/2022

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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 02 B. WING 09/19/2022 155628 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3114 EAST 46TH STREET INDIANAPOLIS, IN 46205 CREEKSIDE HEALTH AND REHABILITATION CENTER (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 failed to ensure 1 of over 100 corridor doors were negatively affected. The provided with a means suitable for keeping the dumbbell to prop open in the door closed, had no impediment to closing, resident room door was latching and would resist the passage of smoke. immediately removed. This deficient practice could affect 15 residents, All residents have the staff and visitors in the 200 Hall. potential to be affected. A tour of the facility was completed Findings include: and no other doors were found propped. Based on observation with the Director of Plant Operations during a tour of the facility from 1:30 Facility staff will be p.m. to 3:00 p.m. on 09/19/22, the door to resident educated on this requirement, room 229 was held open by a handheld dumbell along with current residents. weight placed in front of the door. Based on All facility doors will be interview at the time of the observation, the inspected weekly for 6 weeks Director of Plant Operations agreed the and until 100% compliance is aforementioned corridor door was propped in the achieved, then monthly for 6 fully open position with a handheld weight placed months and until 100% on the floor. compliance is maintained to ensure they are not propped. This finding was reviewed with the Administrator and Director of Plant Operations at the time of exit. The findings of these audits will be presented during 3.1-19(b)the facility's monthly QAPI meetings and the plan of action adjusted accordingly. K 0920 **NFPA 101** SS=B Electrical Equipment - Power Cords and Bldg. 02 Extens Electrical Equipment - Power Cords and **Extension Cords** Power strips in a patient care vicinity are only

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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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u> COM			ETED	
	155628		B. W	B. WING			09/19/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					AST 46TH STREET			
CREEKSIDE HEALTH AND REHABILITATION CENTER				IAPOLIS, IN 46205				
	1	THE INTERIOR SERVICES			GE16, III 16266			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
		ty may not be used for						
	, -	, personal electronics),						
		m care resident rooms that E. Power strips for PCREE						
		r UL 60601-1. Power strips						
		the patient care rooms						
		r the patient date rooms r) meet UL 1363. In						
	· ·	rooms, power strips meet						
		ds. All power strips are used						
		autions. Extension cords						
		substitute for fixed wiring of						
	a structure. Exten	sion cords used						
	temporarily are re	moved immediately upon						
	completion of the	purpose for which it was						
	installed and meets the conditions of 10.2.4.							
	,	9), 10.2.4 (NFPA 99), 400-8						
		(D) (NFPA 70), TIA 12-5						
		on and interview, the facility	K 0	920	1. No residents were		09/28/2022	
		ltiplug adapters were not used			negatively affected. The			
		ixed wiring. LSC 9.1.2 requires			multiplug adapter in the	-1		
		d equipment shall be in FPA 70, National Electrical			resident room was immediat	eıy		
		011 Edition, Article 400.8			removed. 2. All residents have the			
		s specifically permitted, flexible			potential to be affected. All			
	-	all not be used as a substitute			rooms in the facility have be	on		
		a structure. This deficient			inspected for multiplug	···		
	_	et at least 15 residents and staff			adapters with no other			
	in the 200 Hall.				findings.			
	Findings include:				3. Staff will be educated			
					on this requirement. Reside	nts		
	_	e facility with the Director of			and families will be informed	l		
	_	Plant Operations on 09/19/2022 from 1:30 p.m. to			via leaflet and US Mail. All			
		olug adapter was found			resident rooms will be			
		levice and a motorized			inspected weekly for 6 weeks			
		g powerpack in resident room			and until 100% compliance is			
		view at the time of observation,			achieved, then monthly for 6			
		nt Operations agreed that the			months and until 100%			
		vas being used to power			compliance is maintained to			
	electronics. The mi	ıltiplug adapter was removed			ensure no multiplug adapter	5		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155628	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/19/2022		
NAME OF PROVIDER OR SUPPLIER  CREEKSIDE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3114 EAST 46TH STREET INDIANAPOLIS, IN 46205				
(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
	observation.  This finding was re	lant Operations at the time of viewed with the Administrator at Operations at the time of exit.			4. The findings of these au will be presented during the facility's monthly QAPI meeting and the plan of action adjusted accordingly.	gs	

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