DEPARTMEN	PRINTED: 03/28/2025 FORM APPROVED					
_	R MEDICARE & MEDIC					IB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	onstruction 00	(X3) DATE SURVEY COMPLETED	
THI D TETH	or condition	155628	B. WING		03/12/2025	
NAME OF PROVIDER OR SUPPLIER CREEKSIDE HEALTH AND REHABILITATION CENTER			3114 E	ADDRESS, CITY, STATE, ZIP COD EAST 46TH STREET NAPOLIS, IN 46205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	ATE ((X5) COMPLETION DATE
F 0000						
Bldg. 00	IN00454080 and IN Complaint IN0045- related to the allegat F656. Complaint IN0045- the allegations are of Survey dates: Mark Facility number: (nplaint IN00454941 No deficiencies related to allegations are cited. Vey dates: March 11 and 12, 2025 lity number: 009569 Vider number: 155628 I number: 200139920 sus Bed Type: E/NF: 106 al: 106 sus Payor Type:		F-655 Base Line Care Plans F-656 Comprehensive Care F Preparation and/or execution this plan does not constitute admission or agreement by th provider that a deficiency exis This response is also not to b construed as an admission of by the facility, its employees, agents or other individuals wh draft or may be discussed in t response and plan of correction This plan of correction	of ee ets. e fault no his	
				submitted as the facility's cred allegation of compliance. This facility is requesting a de review for compliance.		

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

Based on interview and record review, the facility

failed to ensure 1 of 3 residents reviewed for

pressure ulcers had a baseline care plan

These deficiencies reflect State Findings cited in

Quality review completed on March 14, 2025.

accordance with 410 IAC 16.2-3.1.

TITLE

The facility will ensure this

requirement is met through the

following corrective measures:

(X6) DATE

03/25/2025

LaDonna Lewis-Ogundeji

F 0655

SS=D

Bldg. 00

Other: 5 Total: 106

483.21(a)(1)-(3)

Baseline Care Plan

RN, DON

F 0655

03/25/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZPOR11 Facility ID: 009569 If continuation sheet

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING (00	COMPLETED	
		155628	B. WI	ING		03/12/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIE	R			AST 46TH STREET		
CREEKSIDE HEALTH AND REHABILITATION CENTER					APOLIS, IN 46205		
					I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	• •	lemented within 48 hours of			1. No harm was incurred to		
	admission. (Reside	m D)			(Resident D) by the alleged		
	Findings include:				deficient practice.		
	Findings include:				2. All other residents have the		
	The clinical record	of Resident D was reviewed on			potential to be affected. Care plans will be reviewed for all		
		n. His diagnoses included, but			residents admitted in the last	30	
		metabolic encephalopathy,			days that still reside in the fac		
		rt disease, high blood pressure			to ensure all pertinent problen	-	
	and cognitive impa				are addressed.		
		ease. His admission Minimum			3. The care planning policy w	as	
		sessment, dated 2-26-25,			reviewed. No revisions are		
		vere cognitive impairment and			indicated. Staff were educated	d on	
		a stage 2 pressure ulcer. A			the baseline and comprehens		
		ssion nursing assessment,			care plan policies. A performa		
		cated he was admitted to the			improvement tool has been		
		sure ulcer to the coccyx.			initiated. The DON/designee	will	
	• •	•			audit 10 random resident base		
	A review of Reside	ent D's care plans indicated			care plans to ensure. accurac	у	
	there was not a bas	eline care plan developed for			and completion within 48hrs o	-	
	Resident D related	to skin concerns or pressure			admission weekly x 4 weeks a		
	ulcers.				until 100% compliance is		
					achieved, then 10 residents p	er	
		h the Wound Nurse on 3-12-25			month for 4 months and until		
	_	dicated she and the MDS staff			100% compliance is maintaine		
		or developing care plans for			The DON/designee will audit		
	any skin related iss	ues.			random resident comprehensi	ive	
	_				care plans to ensure patient		
		h the Director of Nursing on			centered focus goals accuracy	-	
	_	n., she indicated a month or so			weekly x 4 weeks and until 10		
	_	an issue with care plans,			compliance is achieved, then		
	_	care plans, not being			residents per month for 4 mor	nths	
		y by the floor nurses. She			and until 100% compliance is		
		as put into QAPI (Quality			maintained.	211	
		formance Improvement, a			4. The findings of these audit		
		the quality of care and safety			be reviewed during the facility		
		and yesterday, 3-11-25, the			monthly QAPI meetings and the	ne	
		service educational offering,			plan of action adjusted		
		ne care plans, in addition to the nurses that all of them can			accordingly.		
	omer issues. Tiell	the nuises that an of them can	I				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	ľ í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155628	B. WIN	G		03/12/	2025
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
			l		AST 46TH STREET		
CREEKS	IDE HEALTH AND	REHABILITATION CENTER		INDIAN	APOLIS, IN 46205		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		the record, not just the MDS		TAG	DEFICIENCE		DATE
		d baseline care plans were a					
		on nursing assessment					
	1 ~	required the nurse to					
	· ·	on" the areas of concern. She					
	1	riewed Resident D's chart, the					
	staff had obtained a	n assessment of the wound to					
	I -	the doctor and family and had					
	· ·	re was an absence of baseline					
	_	s like they did everything they					
	should have, except	for the [baseline] care plans."					
	L interminance 2, 12, 25, 14, 2, 52,						
	In an interview on 3-12-25 at 2:53 p.m., with the Executive Director, she indicated the facility held						
		tional offering on 1-14-25, with					
		on "Admission Assessment					
		d yesterday, 3-11-25, another					
		nal offering addressed baseline					
	care plans. She pro	vided an attendance sign-in					
	sheet, from 1-14-25	, which indicated it was					
	attended by 11 nurs	ing staff persons.					
	On 3-12-25 at 2:53	p.m., the Executive Director					
		a policy and procedure, dated					
	1	Admission of Resident." It					
		e as, "To facilitate a smooth					
		lthcare environment, to help					
		and answer questions the					
		may have [and] to gather					
	comprehensive information as a basis for the planning of careConduct the initial interview and						
	nursing historyConduct a head-to-toe						
	observation/assessment. Identify functional abilities, needs, or problemsinitiate a plan of						
	care."	noolemsmuate a pian of					
	Carc.						
	On 3-12-25 at 1:33	p.m., the Executive Director					
	1	a policy, dated 10/2022,					
		ning." This policy indicated,					
"It is the policy of this facility to develop a							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZPOR11 Facility ID: 009569

If continuation sheet Page 3 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155628		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2025					
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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
F 0656 SS=D Bldg. 00	and reflective of the and services that are maintain the resider mental, and psychos plan of care will inc completed within 48 physician orders, dissocial servicesinit orders" This citation relates 3.1-30(a) 483.21(b)(1)(3) Develop/Implement Based on interview failed to ensure 1 of pressure ulcers had developed and implement of the clinical record of 3-12-25 at 9:25 a.m were not limited to atherosclerotic hear and cognitive impair cerebrovascular discontinuous discontinuous assessment, dated 2 admitted to the facili coccyx.	of care that is individualized, resident's goals, preferences, to be provided to attain or at's highest practical physical, social well-beingA baseline lude at a minimum and will be 3 hours of admission: etary orders, therapy services, ial goals based on admission to Complaint IN00454080. The Comprehensive Care Plan and record review, the facility 3 residents reviewed for a comprehensive care plan emented. (Resident D) Of Resident D was reviewed on and this diagnoses included, but metabolic encephalopathy, at disease, high blood pressure rement following ease. His admission Minimum essment, dated 2-26-25, were cognitive impairment and facility with a stage 2 pressure is admission nursing ease. The care plans indicated at D's care plans indicated	F 0656	The facility will ensure this requirement is met through the following corrective measures 1. No harm was incurred to (Resident D) by the alleged deficient practice. 2. All other residents have the potential to be affected. Care plans will be reviewed for all residents admitted in the last days that still reside in the fact to ensure all pertinent problemare addressed. 3. The care planning policy were reviewed. No revisions are indicated. Staff were educate the baseline and comprehens care plan policies. A perform improvement tool has been initiated. The DON/designee audit 10 random resident bas care plans to ensure. accurace	30 Sility ms vas d on sive ance will e line			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZPOR11 Facility ID: 009569

If continuation sheet

Page 4 of 7

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUI	A. BUILDING <u>00</u>		COMPLETED	
155628		B. WIN	NG		03/12/	2025	
				CTDEET A	DDDECC CITY CTATE ZID COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD AST 46TH STREET		
CDEEK		DELIABILITATION CENTED					
CREEK	SIDE REALTH AND	REHABILITATION CENTER		INDIAN	APOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	F	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	there was not any to	ype of care plan developed for			and completion within 48hrs of	f	
	Resident D related	to skin concerns or pressure			admission weekly x 4 weeks a	ınd	
	ulcers.	•			until 100% compliance is		
					achieved, then 10 residents pe	er	
	In an interview with	h the Wound Nurse on 3-12-25			month for 4 months and until		
	at 1:05 p.m., she in	dicated she and the MDS staff			100% compliance is maintaine	ed.	
	_	or developing care plans for			The DON/designee will audit 1		
	any skin related iss				random resident comprehensi		
					care plans to ensure patient		
	In an interview with	h the Director of Nursing on			centered focus goals accuracy	<i> </i>	
		a., she indicated a month or so			weekly x 4 weeks and until 10		
	•	an issue with care plans not			compliance is achieved, then		
	being conducted routinely by the floor nurses. She shared this issue was put into QAPI (Quality				residents per month for 4 mon		
					and until 100% compliance is		
		Formance Improvement, a			maintained.		
		the quality of care and safety					
		"I tell the nurses that all of			4. The findings of these audits	will	
		lans into the record, not just			be reviewed during the facility		
		ne indicated baseline care plans			monthly QAPI meetings and th		
		nission nursing assessment			plan of action adjusted		
	document and only	requires the nurse to			accordingly.		
	electronically "click	k on" the areas of concern. She					
	added when she rev	viewed Resident D's chart, the					
	staff had obtained a	in assessment of the wound to				ļ	
	his coccyx, notified	the doctor and family and had				ļ	
	care orders, but the	re was an absence of baseline					
	care plans. "It looks	s like they did everything they				ļ	
	should have, except	t for the care plans."				ļ	
						ļ	
	In an interview on 3	3-12-25 at 2:53 p.m., with the				ļ	
	Executive Director,	, she indicated the facility held				ļ	
	an in-service educa	tional offering on 1-14-25, with				ļ	
	the licensed nurses	on "Admission Assessment				ļ	
	and Care Plans," an	nd yesterday, 3-11-25, another				ļ	
	in-service education	nal offering addressed baseline				ļ	
	care plans. She pro	vided an attendance sign-in				ļ	
	sheet, from 1-14-25	, which indicated it was				ļ	
	attended by 11 nurs	sing staff persons.				ļ	
						ļ	
	On 3-12-25 at 2:53	p.m., the Executive Director					
	1						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETI B. WING 03/12/20				
		155628	B. WING	_		03/12/	2025
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
CREEKSIDE HEALTH AND REHABILITATION CENTER					AST 46TH STREET APOLIS, IN 46205		
	<u> </u>			∠1/\(\\/	AI OLIO, II V 4 0200		T
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID	ıv	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	``	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)			
1710		a policy and procedure, dated	1710	_			DATE
	1	Admission of Resident." It					
	indicated its purpos	e as, "To facilitate a smooth					
		althcare environment, to help					
		and answer questions the					
		may have [and] to gather					
		ormation as a basis for the					
	nursing historyCo	Conduct the initial interview and					
		nent. Identify functional					
		problemsinitiate a plan of					
	care."	1					
		p.m., the Executive Director					
		a policy, dated 10/2022,					
		ning." This policy indicated,					
		his facility to develop a					
		of care that is individualized, e resident's goals, preferences,					
		e to be provided to attain or					
		nt's highest practical physical,					
		social well-beingThe facility					
		leted comprehensive plan of					
	care, if present in th	ne initial 48 hours, in place of a					
	Baseline Plan of Ca	-					
		e plan will include a summary					
		f the Resident's: needs,					
	1 -	e history, personal and cultural					
	1 ~	findingsThe resident's care					
	plan will contain measurable objectives and timeframes to meet a resident's medical, nursing,						
		chosocial needsA baseline					
	plan of care will include at a minimum and will be						
	completed within 48 hours of admission:						
	physician orders, di	etary orders, therapy services,					
		tial goals based on admission					
	orders"						
	This siteties 1 4	to Complaint INIO0454000					
	This citation relates to Complaint IN00454080.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $ZPOR11 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 009569$

If continuation sheet

Page 6 of 7

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

PRINTED: 03/28/2025 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICARD SERVICES							OM	IB 110. 0230-032
	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building 00		00	COMPLETED	
			155628	B. WING			03/12/2025	
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	SUMMARY 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 DEFICIENCY)		D BE	COMPLETION
	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION					DATE
		3.1-35(a)						
		3.1-35(b)(1)						
		3.1-35(b)(2)						
		3.1-35(c)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZPOR11 Facility ID: 009569 If continuation sheet Page 7 of 7