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	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Health and Rehabilitation Center	3114 East 46th Street Indianapolis, IN 46205

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure a resident was treated with dignity and respect for 1 of 4 residents reviewed for dignity. (Resident B)Findings include: The clinical record for Resident B was reviewed on 8/21/25 at 12:10 p.m. The diagnoses included, but were not limited to, depression and pain in the right knee. A Quarterly Minimum Data Set assessment, completed 8/5/25, indicated he was moderately cognitively impaired and had severe signs and symptoms of depression.A Psychological Progress Note, dated 8/12/25, indicated he was oriented to person, place, and had mild impairment in thought process. On 8/21/25 at 12:40 p.m., Resident B was observed in his room. He was sitting in his wheelchair by his bed, and the room door was closed. Certified Nurse Aide (CNA) 2 opened the door without knocking. CNA 2 asked Resident B if he was okay and if he had his call light. Resident B responded that he was fine. CNA 2 exited the room, closing the door behind her. Resident B indicated the staff come into his room often without knocking and it bothered him. He wished they would knock before coming in. Resident B then began speaking about his pain medications and indicated the staff did not administer his pain medication correctly. Qualified Medication Aide (QMA) 3 knocked and entered the room as Resident B was discussing his pain medication and sternly told Resident B No we don't. QMA 3 indicated she had Resident B's methadone (routine pain medication). Resident B asked about having his oxycodone (narcotic pain medication). QMA 3, in a sharp tone, informed him that he had his oxycodone earlier in the day and did Resident B want his methadone, if not she would put refused and throw it away. Resident B indicated he would take his methadone and QMA 3 administered the medication to him. QMA 3 then left the room. Resident B became tearful and indicated the staff spoke to him that way all the time. He felt that it was disrespectful. The staff would talk to him like there was something wrong with him and respond like he (the resident) did not know what he was talking about. During an interview on 8/21/25 at 1:00 p.m., CNA 2 indicated she was sorry for busting in the door without knocking. CNA 2 had been worried Resident B did not have his call light and should have knocked before entering. During an interview on 8/21/25 at 1:06 p.m., QMA 3 indicated Resident B asked every day about the pain medications and thought he was getting the wrong medications. She educated him on his medications before giving them.During an interview on 8/22/25 at 12:39 p.m., the Director of Nursing and the Executive Director indicated they expected staff to knock before entering a room and staff should speak to and treat residents with dignity and respect. On 8/21/25 at 11:04 a.m., the Director of Nursing provided the Resident Rights Policy, implemented 3/5/24, which indicated . The resident has a right to be treated with respect and dignity .This citation relates to Complaint 2580039. 3. 1-3(a)3.1-3(t)

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.

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