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	02/11/2026

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

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(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 - Some	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 the residents' dignity was maintained and respected by not using cell phones while assisting with eating (Resident ZZ), and staff turning off the call lights and not returning to the residents' room to provide the services that had been requested (Residents' C, D, E, F, G, H, J, K, L, M, N, P, Q, R, S, T, and V) for 18 of 109 residents reviewed for dignity. Findings include: 1.The Resident Council Minutes binder was provided by the Activities Director on 2/5/26 at 11:00 a.m. The council minutes, dated November 20, 2025, indicated staff were turning off the call lights and not providing the service requested. A resident council meeting was conducted on 2/5/26 at 1:36 p.m. The resident attendees were Residents' C, D, E, F, G, H, J, K, L, M, N, P, Q, R, S and T. During the meeting, they indicated call light response was a problem. It had been brought up in previous resident council meetings and had not been addressed. The staff would come into the room, turn the call light off and indicate they would let the Certified Nursing Assistant (CNA) that was assigned to them know. The staff notified would leave the room, and no one would return to the room often. An interview was conducted with Resident V on 2/5/26 at 3:44 a.m. He indicated the staff would turn the call light off, and the staff would say they would be back. The staff would not return or come back. 2. The clinical record for Resident ZZ was reviewed on 2/9/24 at 2:46 p.m. The resident's diagnosis included, but was not limited to, stroke (blood stopped flowing to a part of the brain). The resident required staff assistance with personal care. A Comprehensive Minimum Data Set (MDS) Assessment, dated 1/28/26, indicated Resident ZZ was cognitively impaired. Resident ZZ had an impairment on both upper extremities. She was dependent on the staff for assistance with eating. An Activities of Daily Living (ADL) care plan, revision date 10/28/25, indicated Resident ZZ required staff assistance with ADLs due to hemiplegia (one side paralysis or weakness) on the left side. An observation was made of Resident ZZ in the dining room with CNA 1 on 2/10/26 at 12:50 p.m. The resident was sitting in her wheelchair at a table with her lunch meal. CNA 1 was sitting in a chair next to Resident ZZ assisting her with eating. When CNA 1 was assisting the resident, she was observed holding her personal cell phone reading content from it at the same time. An interview was conducted with the Director of Nursing, Executive Director and the Nurse Consultant on 2/10/26 at 4:24 p.m. They indicated cell phones should not be used while assisting a resident with her meal. The staff should not be turning off the call lights without providing care and not return to the residents' rooms to provide care after knowledge of care needed. A resident's dignity policy was provided by the Director of Nursing on 2/11/26 at 9:49 a.m. It indicated, .Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.5. When interacting with a resident, pay attention to the resident as an individual. 6. Respond to requests for assistance in a timely manner. The citations are relates to Intakes 2727293, 2723240 and 2731292.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to timely address a resident's skin condition; to ensure a resident's fall interventions were implemented; to obtain a resident's heart rate and medication hold perimeters were followed; address a resident's ear wax buildup; to ensure weights were obtained and the provider was notified of out of parameter weights for 5 of 10 residents reviewed for Quality of Care. (Residents BB, 86, 3, E, and V) Findings include: 1 The clinical record for Resident BB was reviewed on 2/5/26 at 2:52 p.m. The resident's diagnosis included, but was not limited to, quadriplegia (loss of sensation and function of all four limbs and torso). A Quarterly Minimum Data Set (MDS) Assessment, completed 11/10/25, indicated he was cognitively intact, frequently incontinent of urine, and dependent for toilet hygiene. He had no moisture associated skin damage (MASD). A shower sheet, dated 12/2/25, indicated Resident BB had a bed bath. There were no skin areas of concern marked on the shower sheet. A shower sheet, dated 12/9/25, indicated Resident BB had a bed bath. There were no skin areas of concern marked on the shower sheet. A Skin Sweep and Risk Assessment Tool, dated 12/11/25, indicated Resident BB had an open area on the left gluteal (buttock) that was moisture associated skin damage. There were no measurements or descriptions of the open area on the left gluteal. The clinical record did not indicate the physician had been notified and that a new treatment order had been obtained on 12/11/25. A physician's order, dated 12/15/25, indicated to cleanse left and right gluteus with normal saline, pat dry. Mix triad (cream for wound treatment) and collagen powder together and apply to wound bed and cover with a foam dressing. Change the dressing daily and as needed if soiled or dislodged. A Moisture Associated Skin Damage (MASD) evaluation, dated 12/16/25, indicated the open area on the left gluteus was a new wound, IAD Incontinence Associated Dermatitis acquired in-house (at facility). The measurements of the open area were 2.35 centimeters (cm) in length, 5.9 cm in width, and 0.1 cm in depth. During an interview on 2/5/26 at 2:52 p.m., Resident BB indicated he had an open area on his buttocks. The staff were caring for his wound. He took Lasix (diuretic) twice a day and urinated a lot. He did not feel he was getting changes as often as he needed to be. A care plan, last revised on 2/7/26, indicated Resident BB was at risk for developing pressure ulcers related to change in mobility. He had decreased sensory perception, incontinence, and one or more diagnosis that put him at higher risk. The goal was to be minimized to no open areas through care plan interventions. The interventions included, but were not limited to, staff to provide incontinent care and apply barrier cream as needed, observe for redness, tenderness, or changes in his skin, observe skin weekly and as needed. During an interview on 2/10/26 at 2:11 p.m., the Director of Nursing (DON) indicated the area on Resident BB's buttocks had been noted on 12/11/25. The nurse who identified the area was not sure (continued on next page)

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	155628	A. Building B. Wing	02/11/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if the area was open or scar tissue. The staff were using barrier cream as a protectant. The wound nurse assessed the wound on 12/15/25 and a new treatment was started. During an interview on 2/11/26 at 9:49 a.m., the DON indicated there was no care plan about Resident BB's buttock wound. 2.a. The clinical record for Resident 86 was reviewed on 2/5/26 at 3:27 p.m. The resident's diagnosis included, but was not limited to, hypotension (low blood pressure). A physician's order, dated 11/13/25, indicated the resident was to receive droxidopa (medication to treat orthostatic hypotension) 500 milligrams (mg) three times a day. The staff were to hold the resident's droxidopa for a systolic blood pressure (top number of blood pressure) greater than 140. A physician's order, dated 12/4/25, indicated the resident was to receive midodrine (medication to treat orthostatic hypotension) 10 mg three times a day. The staff were to hold the resident's midodrine for a systolic blood pressure greater than 140. The January and February 2025 Medication Administration Records (MAR) indicated Resident 86 had received droxidopa and/or midodrine when his systolic blood pressure was greater than 140 on the following days: 1/ 4, 1/10, 1/12, 1/15, 1/23, 1/24, 1/31, 2/1, 2/5, and 2/7/26. During an interview on 2/10/26 at 3:06 p.m., the DON indicated Resident 86's droxidopa and midodrine medications should have been held if his systolic blood pressure was greater than 140. 2.b. A care plan, last reviewed on 11/25/25, indicated Resident 86 was at risk for falls related to a history of falls, ataxia (lack of voluntary muscle coordination resulting in unsteady, clumsy, or awkward movements), and orthostatic hypotension (a sudden drop in blood pressure upon standing from a sitting or lying position). The goal was that his care plan interventions would minimize the risk for falls with serious injury. The interventions included, but were not limited to, medication review, remove pedals off resident wheelchair, and a soft touch call light in place. On 2/9/26 at 10:50 a.m., Resident 86 was observed in his room sitting in his wheelchair by his bed. His feet were on his wheelchair pedals. A push-button call light was present on his bed. On 2/9/26 at 3:16 p.m., Resident 86 was observed in his room sitting in his wheelchair. His feet were positioned on his foot pedals, and a push button call light was present on his bed. On 2/10/26 at 12:06 p.m., Resident 86 was observed sitting in his wheelchair in the dinning room with his foot pedals on and his feet resting on the foot pedals. During an interview on 2/10/26 at 12:21 p.m., Licensed Practical Nurse (LPN) 8 indicated the resident had a push-button call light in his room, which he was able to use. LPN 8 would check to see if he was supposed to have a soft touch call light. Resident 86 was using foot pedals on his wheelchair. During an interview on 2/10/26 at 3:06 p.m., the DON indicated Resident 86 had been moved closer to the nurses' station and his soft touch call light had not been moved with him. Resident 86 had started using foot pedals on his wheelchair after he had a fractured ankle in late January 2026. 3. The clinical record for Resident 3 was reviewed on 2/11/26 at 10:53 a.m. The resident's diagnosis (continued on next page)

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	155628	A. Building B. Wing	02/11/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included, but was not limited to, hypertension (high blood pressure). The hypertension care plan, revised on 10/31/25, indicated the resident's interventions, initiated on 1/12/26, was for staff to hold the resident's antihypertensive medication for a systolic blood pressure (SBP) below 110, a diastolic blood pressure (DBP) below 60, or a heart rate (HR) below 60. The physician's orders indicated staff were to administer one 25 mg tablet of Metoprolol Tartrate two times a day. The staff were to hold the resident's Metoprolol for SBP below 110, a DBP below 60, or HR below 60, starting 1/21/26. The February 2026 medication administration record (MAR) included documented blood pressures, but no documented heart rates for the resident's medication administration. The MAR indicated the resident's medication was administered twice daily from 2/1/26 through 2/10/26, except the a.m. administrations on 2/4/26 (refused) and 2/6/26 (blood pressure out of parameters.) Eight of the dates the resident received his Metoprolol administrations from 2/1/26 through 2/10/26, the resident's DBP's was under 60. The pulse rates in the vitals section of the resident's electronic health record lacked pulse rates documented on the following days: 2/2/26, 2/3/26, 2/4/26, 2/6/26, 2/7/26, and 2/8/26. An interview was conducted with the Director of Nursing (DON) on 2/11/26 at 12:25 p.m. She indicated she found verification of a pulse rate obtained on 2/2/26, but had no verification of any pulse rates for the administrations of Metoprolol on 2/3/26, 2/4/26, 2/6/26, 2/7/26, and 2/8/26. When the order was entered into the electronic health record, they set it up to include the blood pressures, but not the resident's heart rates. 4. The clinical record for Resident V was reviewed on 2/6/26 at 12:00 p.m. The resident's diagnosis included, but was not limited to, cerebral palsy (permanent, non-progressive neurological disorder). The ADL care plan, revised 8/26/25, indicated the resident required total staff assistance with his activities of daily living. The physician's orders indicated to provide a complete bed bath every shift, starting 2/11/20. An observation of Resident V was made with the Housekeeping Supervisor/Certified Nursing Assistant (HS/CNA) on 2/10/26 at 11:00 a.m. Resident V was lying in bed, the resident's right ear had shimmery wax easily observed inside of his ear. There was a thick amount of darker colored wax at the start of his ear canal. There was a ball of dry wax hanging, easily observed in the left ear. During the observation on 2/10/26 at 11:00 a.m., Licensed Practical Nurse (LPN) 3 entered the resident's room. The LPN indicated the CNAs should have informed the nurse when a resident had a large amount of ear wax so the nurse could inform the physician or audiology provider. She would have thought the CNAs would have notified the nurse if they recognized it. The LPN indicated she would reach out to the physician. The February, 2025 TAR (treatment administration record) indicated Resident V was provided a complete bed bath every shift from 2/1/26 through 2/10/26. 5.The clinical record for Resident E was reviewed on 2/6/25 at 2:46 p.m. The resident's diagnosis included, but was not limited to, acute kidney disease. (continued on next page)

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	155628	A. Building B. Wing	02/11/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, dated 11/4/25, indicated Resident E received furosemide medication for weight gain. The intervention indicated the staff were to administer the resident's medication as ordered. A physician's order, dated 11/5/25, indicated the staff were to provide 20 milligrams of furosemide as needed (PRN) if the resident's weight gain was over 2 pounds in 24 hours or 5 pounds in 1 week. A physician's order, dated 1/7/26, indicated Resident E was to receive 20 milligrams of furosemide daily for edema and weight gain. A physician's order, dated 12/2/25, indicated the staff was to obtain Resident E's weight in the morning for congested heart failure. The order was discontinued on 1/27/28. A physician's order, dated 1/28/26, indicated Resident E was to be weighed before breakfast. The staff were to notify the physician if the resident had a weight gain of 2 pounds over 24 hours or 5 pound weight gain in 1 week. If the resident refused, the staff were to provide education and document in the medical chart. The January 2026 and February 2026 Medication/Treatment (MAR/TAR) Records indicated the following days Resident E's weight was not obtained, the physician was not notified, or the PRN 20 milligrams of furosemide was administered as ordered: -On 1/4/26, the resident's weight recorded was 203.6 and on 1/5/26, the resident's weight recorded was 209 (5.4 pounds weight gain in 1 day); the physician was not notified and 20 milligrams of furosemide PRN was not administered. -On 1/18/26, the resident's weight was not obtained. -On 1/27/26, the resident's weight was not obtained. -On 2/5/26, the resident's weight recorded was 205.6 and on 2/6/26, the resident's weight recorded was 209 (3.4 pounds weight gain in 1 day); the physician was not notified and 20 milligrams of furosemide PRN was not administered. -On 2/8/26, the resident's weight was not obtained. An interview was conducted with the Director of Nursing on 2/10/26 at 2:27 p.m. She indicated she was unable to provide weights that had been obtained on 1/18/26, 1/27/26, and 2/8/26. She could not find any documentation the medical provider was notified when Resident E's weights were within the parameters of notifying the medical provider as ordered. A weight policy was provided by the Director of Nursing on 2/10/26 at 2:27 p.m. It indicated, Purpose.2. To provide an ongoing record of the resident's body weight as an indicator of the nutritional status and medial condition of the resident.Procedure: .5. The physician will be notified of significant weight changes by nursing. On 2/9/26 at 2:41 p.m., the Nurse Consultant provided the Accidents and Supervision Policy, last revised 10/8/24, that read .The resident environment will remain as free of accidents hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.3. Implementation of Interventions.e. Ensuring that the interventions are put into action.4. (continued on next page)

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	155628	A. Building B. Wing	02/11/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitoring and Modifications.Monitoring and modification process included: a. Ensuring that interventions are implemented correctly and consistently b. Evaluating the effectiveness of interventions c. Modifying or replacing interventions as needed d. Evaluating the effectiveness of new interventions. The Medication Administration policy was provided by the DON on 2/10/26 at 11:12 a.m. It indicated, Ensure blood pressure, pulse or other vital sign parameters are completed prior to administering medication(s) that require parameters. On 2/11/26 at 9:49 a.m., the DON provided the Skin Integrity and Pressure Injury Policy, last revised 2/2025, that read .After a wound or skin condition is identified: 1. Complete an assessment of the area. 2. Notify the physician and resident representative. 3. Recommend a treatment to the physician that is considered appropriate and n compliance with the current standards of practice for wound healing .4. Complete the treatment as ordered . 6. Document in the medical record . The Bed Baths policy was provided by the DON (Director of Nursing) on 2/11/26 at 11:15 a.m. It indicated, Wash the resident's ears (behind the ears and gently inside the ears) and neck, rinsing and drying the areas.Inspect the skin along the way noting any open areas, bruising, or other signs of skin breakdown and notify the nurse if noted. The citations relates to Intakes 2727293, 2723240 and 2731292. 3.1-37

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff donned Personal Protective Equipment(PPE) prior to entering a room of a resident in contact isolation precautions and prior to performing tracheostomy care for a resident in enhanced barrier precautions, to ensure hand hygiene was performed after doffing (removing) gloves, and to ensure a resident's catheter bag was correctly positioned for 1 resident randomly observed for contact isolation, 1 of 1 resident reviewed for tracheostomy and 2 of 2 residents reviewed for urinary catheter care (Resident 22, Resident 1,and Resident 80).Findings include:1 The clinical record for Resident 22 was reviewed on 2/9/26 at 3:21 p.m. The resident's diagnosis included, but was not limited to, hypertension (high blood pressure). On 2/9/26 at 3:21 p.m., Resident 22's room was observed to have a sign posted on the door frame that indicated she was in Contact Isolation Precautions. An isolation cart was located outside of her door and contained disposable gowns and gloves. Registered Dietician (RD) 4 did not have an isolation gown or gloves on and was standing at Resident 22's bedside, assisting her to drink from a straw. During an interview on 2/9/26 at 3:25 p.m., RD 4 indicated she had not seen the contact isolation precaution sign prior to entering the room. She should have donned PPE prior to going into Resident 22's room to assist the resident. 2. The clinical record for Resident 1 was reviewed on 2/6/26 at 2:53 p.m. The resident's diagnosis included, but was not limited to, tracheotomy status (artificial airway to enable breathing). A care plan, last revised on 1/28/26, indicated Resident 1 required enhanced barrier precautions related to having a supra pubic catheter, tracheostomy, and wounds. An intervention was for staff to follow enhanced barrier precautions. On 2/11/26 at 9:50 a.m., the Respiratory Therapist (RT) was observed performing tracheostomy care for Resident 1. The RT prepared the supplies, performed hand hygiene (HH), and donned sterile gloves. The RT did not don an isolation gown when performing tracheostomy care for Resident 1. During an interview on 2/11/26 at 10:11 a.m., the RT indicated she should have donned a gown prior to providing tracheostomy care since Resident 1 was in enhanced barrier precautions. On 2/11/26 at 10:00 a.m., Licensed Practical Nurse (LPN) 5 was observed performing catheter care for Resident 1. LPN 5 gathered the supplies, performed HH, and donned an isolation gown and gloves. She removed the soiled dressing from Resident 1's urinary catheter site. LPN 5 doffed her gloves and donned a new pair of gloves without performing HH. She cleansed Resident 1's urinary catheter site and doffed her gloves. She did not perform HH and donned a new pair of gloves. LPN 5 rinsed the catheter site and doffed her gloves. LPN 5 did not perform HH and donned a new pair of gloves. LPN 5 then applied a new dressing to Resident 1's urinary catheter site. During an interview on 2/11/26 at 10:08 a.m., LPN 5 indicated she normally performed HH when changing her gloves. 3. The clinical record for Resident 80 was reviewed on 2/5/26 at 2:30 p.m. Her diagnoses included, but were not limited to, failure to thrive. She had been receiving hospice services in the facility since 3/1/25. (continued on next page)

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	155628	A. Building B. Wing	02/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The indwelling catheter care plan, revised 11/21/25, indicated an intervention was that she would receive teaching on proper positioning of the drainage bag. An observation of Resident 80, lying in bed in her room, was made on 2/5/26 at 2:39 p.m. Her bed was in a low position, and her catheter bag was hanging from the right side of her bed, resting on the floor. An observation of Resident 80, lying in bed in her room, was made on 2/9/26 at 11:37 a.m. Her bed was in a low position, and her catheter bag was hanging from the right side of her bed, resting on the fall mat on the floor. An interview was conducted with Family Member 7, who was visiting with Resident 80, on 2/9/26 at 11:37 a.m. He indicated Resident 80 had a couple of urinary tract infections recently. The last one was at Christmas time in 2025. Resident 80's catheter bag was always resting on the floor or on the fall mat when he visited. An observation of Resident 80, lying in bed in her room, was made with LPN (Licensed Practical Nurse) 3 on 2/9/26 at 11:49 a.m. An interview was conducted with LPN 3 at this time. Resident 80's catheter bag remained resting on the fall mat on the floor. LPN 3 indicated they kept the bag positioned on the floor or fall mat, because if they had her bed higher, she may fall out of bed, and she was a fall risk, so they had to have the bed in a low position with the catheter bag resting on the floor or fall mat. LPN 3 did not adjust the position of the catheter bag to not touch the fall mat. An observation of Resident 80, lying in bed in her room, was made on 2/10/26 at 10:43 a.m. Her bed was in a low position, and her catheter bag was hanging from the left side of her bed, resting on the fall mat on the floor. An interview was conducted with Resident 80's Hospice RN (Registered Nurse) on 2/10/26 at 3:34 p.m. He indicated he'd been Resident 80's hospice nurse since March of 2025. Resident 80's catheter bag should not be touching the floor. When he visited, he lowered her bed as low as it could go without her catheter bag touching the floor. If it touched the floor, her bed needed to be raised. Falling was a concern, but her catheter bag still should not touch the floor. He noticed it on the floor when he arrived, so he would reposition the bed and catheter bag, so that it would not be resting on the floor. Most times he arrived to visit, her catheter bag was resting on the floor. He ensured it was not on the floor every time he left. The Catheter Care policy was provided by the ED (Executive Director) on 2/10/16 at 4:00 p.m. It indicated, Ensure tubing and catheter bag does not touch the floor. Residents with low beds may require a different intervention/alternative to keep catheter bags and tubing from touching the floor such as: Put the [name brand of catheter] bag and any extra tubing into a new or clean wash basin and sit the basin on the floor next to the bed. Some residents move a lot at night, and the basin may slide, depending on your floors. The [name brand of catheter] bag could slip out. Use some no-slip or [name brand of no-slip material] on the floor under the basin to keep it from sliding around. There are also [name brand of catheter] bag floor stands to keep the bag from touching the floor. However, if the resident moves a lot, these can tip over easily. They also might require [name brand of no-slip material] to prevent sliding. This same product can mount to wheelchairs in several places. Some facilities also use a 'low profile' [brand name of catheter] bag. It's about half the size of the regular bag, about 1000 cc or less, so it may need to be emptied more often than a regular size bag, which can hold 2000 to 4000 cc, depending on the brand your facility uses. (continued on next page)

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	155628	A. Building B. Wing	02/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/9/26 at 4:03 p.m., the ED provided the Transmission-Based (Isolation) Precautions Policy, last revised 6/11/25, that read .It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. Contact Precautions.c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. On 2/11/26 at 11:30 a.m., the Director of Nursing (DON) provided the Enhanced Barrier Precautions Policy, last revised 2/5/25, that read . Definitions: 'Enhanced barrier precautions' [EBP] refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. 3.1-18(a)

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	02/11/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to ensure a resident was provided with heel protective boots, as ordered, and ensure timely follow-up with podiatry services for 1 of 3 residents reviewed for foot care. (Resident V) Findings include: The clinical record for Resident V was reviewed on 2/6/26 at 12:00 p.m. The resident's diagnoses included, but were not limited to, cerebral palsy (neurological disorder that permanently affects body movement), seizure disorder (recurrent, unprovoked seizures), and aphasia (impaired ability to speak, write, and understand language). An interview was conducted with Family Member 4 on 2/6/26 at 12:01 p.m. The family member indicated there was an ongoing issue at the facility with them not trimming Resident V's toenails.The ADL care plan, with a revision date of 8/26/25, indicated Resident V required total staff assistance with his activities of daily living. The current physician's order, dated 3/24/20, indicated the resident was to always have Prevalon boots (a heel protection boot for pressure relief) on every shift for preventive measures. The February 2025 treatment administration record (TAR) indicated Resident V had his Prevalon boots on every day, every shift, including first shift on 2/10/26. An interview and observation of Resident V was made with the Housekeeping Supervisor/CNA (HS/CNA) on 2/10/26 at 11:00 a.m. Resident V was lying in bed with a blanket over him. The HS/CNA lifted the resident's blanket to reveal the resident's feet. The resident's feet were bare, and he was not wearing any Prevalon boots. His left big toenail was long and jagged. The first three toenails on his right foot were very long. The HS/CNA indicated his toenails needed filed or trimmed. During the observation on 2/10/26 at 11:00 a.m., LPN (Licensed Practical Nurse) 3 entered the resident's room. The LPN looked at Resident V's toenails and indicated, They need clipped. At that time, LPN 3 looked around Resident V's room, including in his drawers and closet and was unable to locate any Prevalon boots. The LPN indicated Resident V didn't have any boots and the resident would need to be referred to podiatry for his toenails. LPN 3 reviewed the resident's February 2026 TAR and indicated she had already signed off the resident's TAR to indicate Resident V had his Prevalon boots in place today. An interview was conducted with the Social Services Director (SSD) and LPN 3 on 2/10/26 at 11:21 a.m. LPN 3 informed the SSD that Resident V needed to see podiatry (foot specialist). The SSD indicated they needed to be notified by staff that a resident needed to be seen by podiatry for them to be placed onto the podiatry list. No one said anything prior about Resident V needing to be seen by podiatry services. The last time podiatry was in the facility was 1/7/26. During an interview, on 2/10/26 at 11:21 a.m., the SSD provided Resident V's last podiatry consultation note. The resident's podiatry note, dated 10/6/25, indicated Resident V met the qualifications for routine or at-risk footcare. The Assessment/Plan section indicated, Stressed importance of regular podiatry care and pedal hygiene. The Follow Up section indicated, At Risk Footcare established patient exam in 2 to 3 months. The SSD was unable to provide any follow up podiatry consultation notes after the 10/6/25 note for Resident V. Resident V had not received a 2-to-3-month follow-up as indicated in his assessment plan. The Podiatry Services policy was provided by the ED (Executive Director) on 2/10/26 at 4:00 p.m. It indicated, It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health.4. Employees should refer any identified need for foot care to the social worker or designee. 5. The social worker or designee will assist residents in making appointments and arranging transportation to obtain needed services. 3.1-47(a)(7)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to provide a resident's palm protector, per his functional maintenance program, for 1 of 1 resident reviewed for limited range of motion. (Resident V) Findings include: The clinical record for Resident V was reviewed on 2/6/26 at 12:00 p.m. The resident's diagnosis included, but was not limited to: contractures (a permanent or long-term tightening, shortening, and hardening of muscles, tendons, ligaments, or skin, causing joint deformity and reduced, painful range of motion). An observation of Resident V was made in his room on 2/5/26 at 3:00 p.m. He was sitting in his wheelchair in his room and his left hand was contracted. The resident had no splint, carrot, or pal protector in place. There were no physician's orders for a splint, carrot, or palm protector for the resident's left hand. The ADL care plan, revised 8/26/25, indicated the resident needed total assistance with his activities of daily living. The interventions were for staff to encourage him to wear his left-hand palm protector for up to 4 to 8 hours a day, wash his hands, dry his hands, and stretch his hands before applying hand splints. An observation of Resident V was made with the Housekeeping Supervisor/Certified Nursing Assistant (HS/CNA) on 2/10/26 at 11:00 a.m. During an interview the HS/CNA indicated in the past, at one time, she had seen a palm protector for Resident V. The resident was observed lying in bed and no left-handed palm protector was in place. On 2/10/26 at 11:00 a.m., Licensed Practical Nurse (LPN) 3 entered the resident's room. During an interview, at that time, the LPN indicated she had worked the hall full time since November, 2025 and she did not know anything about the resident using a palm protector or having an order for it. She had never seen him with a left-hand palm protector. LPN 3 looked in Resident V's drawers and closets and was unable to locate a palm protector. An interview was conducted with the Therapy Manger (TM) on 2/11/26 at 10:35 a.m. She indicated Resident V had a functional maintenance plan (FMP) created when he was discharged from therapy in February of 2024. On 2/11/26 at 11:10 a.m., the TM provided the 2/23/24 FMP for Resident V. The FMP indicated the problem/needs were contractures to both hands. His current functional status was that he tolerated a left-hand palm protector for up to 4 to 8 hours. The goal was to maintain tolerance of splint, wear to maintain skin hygiene and integrity, and prevent further contractures. The recommendations/approaches were to encourage wear of bilateral hand splints for up to 4 to 8 hours. The Use of Assistive Devices policy was provided by the ED (Executive Director) on 2/10/26 at 4:04 p.m. It indicated, The facility will provide assistive devices for residents who need them.Direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the devices.A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. 3.1-42(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely implement provision of a resident's nutritional supplements for 1 of 1 resident reviewed for nutrition. (Resident 25) Findings include:The clinical record for Resident 25 was reviewed on 2/6/26 at 12:30 p.m. Her diagnosis included, but was not limited to, dementia (mental decline). An interview was conducted with Family Member 2 on 2/6/26 at 12:38 p.m. The family member indicated Resident 25 hadn't been eating very well lately and had lost weight. The weights in the vitals section of the electronic health record indicated the resident had the following weights on the following dates: -On 1/12/26, the resident weighed 145.8 pounds-On 1/22/26, the resident weighed 149.8 pounds-On 1/26/26, the resident weighed 150 pounds-On 2/01/26, the resident weighed 142.8 pounds-On 2/02/26, the resident weighed 142.4 pounds The nutrition care plan, revised on 1/13/26, indicated the resident's intervention was for her to receive her diet, as ordered. The hospital discharge instructions, dated [DATE], indicated the resident's discharge diet was regular with ensure supplements. The facility physician's orders and medication administration records (MAR) indicated the resident's ensure supplement did not begin until 2/05/26. The 1/13/26 nutrition assessment indicated Resident 25 was malnourished due to decreased appetite/intakes, recent weight loss, reduced mobility, recent acute illness, and dementia. The recommendations were for her to have a magic cup with lunch and dinner. The facility physician's orders and MAR indicated the magic cup supplements did not begin until 2/05/26. An interview was conducted with the Assistant Director of Nursing (ADON) on 2/11/26 at 11:00 a.m. The ADON indicated the resident's ensure and magic cup supplements were not starting until 2/5/26, and it was an oversight. The Nutritional and Dietary Supplements policy was provided by the ED (Executive Director) on 2/10/26 at 4:00 p.m. It indicated, The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs. 3.1-46(a)(2)