STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAIL CREEK PLACE	1400 E COOLSPRING AVE, MICHIGAN CITY, , 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 466673. Intake 466673 - State deficiencies related to the allegations are cited at R0036, R0241 and R0243. Survey date: December 22 and 23, 2025 Facility number: 010610 Residential Census: 70 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/29/25.	R 0000		
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has	R 0036		01/06/2026

noticed:

(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or

(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.

Based on record review and interview, the facility failed to notify a resident's responsible party of a change of condition which resulted in a new medication being administered for 1 of 3 residents reviewed for physician and responsible party notification. (Resident B)

Finding includes:

Resident B's record was reviewed on 12/22/25 at 10:01 a.m. The diagnoses included, but were not limited to, stroke, dementia, and diabetes.

The Service Plan, dated 12/9/25, indicated the resident required assistance with daily decision making.

A Nurses Note, dated 11/04/25 at 11:00 a.m., indicated Resident B was noted to be anxious and unable to sit still. The resident was moving from her bed to the recliner repeatedly. The Nurse Practitioner (NP) was in the

facility and a new order was received to administer Benadryl 50 milligrams (mg) intramuscular (IM) now for one dose. Benadryl was given in the left gluteal as ordered.

A Physician's Order, dated 11/4/25, indicated Benadryl 50 mg IM was to be given one time.

The resident's responsible party had not been notified of the resident's change of condition and the new medication that had been ordered and administered.

During an interview on 12/22/25 at 12:02 p.m., LPN 1 indicated the NP was in the facility and Resident B could not calm down. The NP had ordered Benadryl IM once to be given immediately and she retrieved the medication for the EDK and administered the medication to the resident. LPN 1 indicated she had not notified the responsible party prior to administering the Benadryl.

During an interview on 12/22/25 at 11:05 a.m., the Executive Director indicated she understood the concern and the responsible party should have been notified prior to administering the medication. No further documentation was provided.

A policy, received as current and titled, "Resident Change of

Condition" was provided by the Executive Director on 12/22/25 at 9:11 a.m. The policy stated, ... "acute medical change, b. The Family, responsible party,case manager, and or other designated parties will be notified that there has been a change in the resident's condition and what steps are being taken...".

This citation relates to Intake 466673.

Based on record review and interview, the facility failed to notify a resident's responsible party of a change of condition which resulted in a new medication being administered for 1 of 3 residents reviewed for physician and responsible party notification. (Resident B)

Finding includes:

Resident B's record was reviewed on 12/22/25 at 10:01 a.m. The diagnoses included, but were not limited to, stroke, dementia, and diabetes.

The Service Plan, dated 12/9/25, indicated the resident required assistance with daily decision making.

A Nurses Note, dated 11/04/25 at 11:00 a.m., indicated Resident B was noted to be anxious and unable to sit still. The resident was moving from her bed to the recliner

repeatedly. The Nurse Practitioner (NP) was in the facility and a new order was received to administer Benadryl 50 milligrams (mg) intramuscular (IM) now for one dose. Benadryl was given in the left gluteal as ordered.

A Physician's Order, dated 11/4/25, indicated Benadryl 50 mg IM was to be given one time.

The resident's responsible party had not been notified of the resident's change of condition and the new medication that had been ordered and administered.

During an interview on 12/22/25 at 12:02 p.m., LPN 1 indicated the NP was in the facility and Resident B could not calm down. The NP had ordered Benadryl IM once to be given immediately and she retrieved the medication for the EDK and administered the medication to the resident. LPN 1 indicated she had not notified the responsible party prior to administering the Benadryl.

During an interview on 12/22/25 at 11:05 a.m., the Executive Director indicated she understood the concern and the responsible party should have been notified prior to administering the medication. No further documentation was provided.

	A policy, received as current and titled, "Resident Change of Condition" was provided by the Executive Director on 12/22/25 at 9:11 a.m. The policy stated, ... "acute medical change, b. The Family, responsible party,case manager, and or other designated parties will be notified that there has been a change in the resident's condition and what steps are being taken...". This citation relates to Intake 466673.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.	R 0241		01/06/2026

	Based on record review and interview, the facility failed to provide care as ordered related to the delay of obtaining a urinalysis (UA) which resulted in a hospitalization for 1 of 3 residents reviewed for Urinary Tract Infection (UTI). (Resident B) Finding includes: Resident B's record was reviewed on 12/22/25 at 10:01 a.m. The diagnoses included, but were not limited to, stroke, dementia, and diabetes. The Service Plan, dated 12/9/25, indicated the resident required assistance with daily decision making. A Nurse's Note, dated 10/31/25 at 2:50 p.m., indicated the resident's daughter had stated her mom appeared a bit confused today and had been more incontinent than usual. The daughter stated there was a long history of UTI's and requested a urinalysis test. The NP was notified and in agreement. A Physician's Order, dated 10/31/25, indicated, may obtain UA and C (culture) & S (sensitivity) due to increased confusion/incontinence. A Nurses Note, dated 11/2/25 at 11:00 a.m., indicated the U/A had been collected and would			

	be picked up by [transportation company name] on 11/3/25. A Nurses Note, dated 11/4/25 at 11:00 a.m., indicated the resident was noted to be anxious and unable to sit still. The resident was moving from her bed to the recliner repeatedly. The Nurse Practitioner (NP) was in the facility and a new order was received to administer Benadryl 50 milligrams (MG) intramuscular (IM) now for one dose. Benadryl was given in left gluteal as ordered. A Nurse's Note, dated 11/4/25 at 9:47 p.m., indicated a hospital nurse called and notified staff that the resident was being admitted. A Nurse's Note, dated 11/5/25 at 6:45 a.m., indicated LPN 1 had spoken with the nurse at the hospital and Resident B was admitted with encephalopathy and UTI. During an interview on 12/22/25 at 12:02 p.m., LPN 1 indicated their UA's were sent to a lab in Texas through [transportation company]. The transportation company will not do Sunday pickups, which is why the resident's urine was sent out on 11/3/25. The results came back on 11/5/25 and the resident was already in the hospital. She couldn't recall why they were to			

	obtain a urinalysis because the resident was adjusting well with no issues to the facility until 11/4/25, when she became agitated. She had indicated they tried to get the resident's urine prior to 11/2/25 but the resident kept moving the hat from the toilet seat. She had not documented her unsuccessful attempts to collect the urine or notified the physician or NP. During an interview on 12/23/25 at 9:29 a.m., The Executive Director indicated she had admitted Resident B due to the Director of Nursing being off. She had offered that day to send Resident B out for evaluation because the resident's daughter had indicated that she thought her mom was acting differently. The daughter had declined and asked for a UA. She understood the concern and had no additional information to provide. This citation relates to Intake 466673. Based on record review and interview, the facility failed to provide care as ordered related to the delay of obtaining a urinalysis (UA) which resulted in a hospitalization for 1 of 3 residents reviewed for Urinary Tract Infection (UTI). (Resident B)			

	Finding includes: Resident B's record was reviewed on 12/22/25 at 10:01 a.m. The diagnoses included, but were not limited to, stroke, dementia, and diabetes. The Service Plan, dated 12/9/25, indicated the resident required assistance with daily decision making. A Nurse's Note, dated 10/31/25 at 2:50 p.m., indicated the resident's daughter had stated her mom appeared a bit confused today and had been more incontinent than usual. The daughter stated there was a long history of UTI's and requested a urinalysis test. The NP was notified and in agreement. A Physician's Order, dated 10/31/25, indicated, may obtain UA and C (culture) & S (sensitivity) due to increased confusion/incontinence. A Nurses Note, dated 11/2/25 at 11:00 a.m., indicated the U/A had been collected and would be picked up by [transportation company name] on 11/3/25. A Nurses Note, dated 11/4/25 at 11:00 a.m., indicated the resident was noted to be anxious and unable to sit still. The resident was moving from her bed to the recliner repeatedly. The Nurse			

	Practitioner (NP) was in the facility and a new order was received to administer Benadryl 50 milligrams (MG) intramuscular (IM) now for one dose. Benadryl was given in left gluteal as ordered. A Nurse's Note, dated 11/4/25 at 9:47 p.m., indicated a hospital nurse called and notified staff that the resident was being admitted. A Nurse's Note, dated 11/5/25 at 6:45 a.m., indicated LPN 1 had spoken with the nurse at the hospital and Resident B was admitted with encephalopathy and UTI. During an interview on 12/22/25 at 12:02 p.m., LPN 1 indicated their UA's were sent to a lab in Texas through [transportation company]. The transportation company will not do Sunday pickups, which is why the resident's urine was sent out on 11/3/25. The results came back on 11/5/25 and the resident was already in the hospital. She couldn't recall why they were to obtain a urinalysis because the resident was adjusting well with no issues to the facility until 11/4/25, when she became agitated. She had indicated they tried to get the resident's urine prior to 11/2/25 but the resident kept moving the hat from the toilet seat. She had not documented her unsuccessful			

	attempts to collect the urine or notified the physician or NP. During an interview on 12/23/25 at 9:29 a.m., The Executive Director indicated she had admitted Resident B due to the Director of Nursing being off. She had offered that day to send Resident B out for evaluation because the resident's daughter had indicated that she thought her mom was acting differently. The daughter had declined and asked for a UA. She understood the concern and had no additional information to provide. This citation relates to Intake 466673.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.	R 0243		01/06/2026

Based on record review and interview, the facility failed to ensure medication was given as ordered for 1 of 3 residents reviewed for medication administration. (Resident B)

Finding includes:

Resident B's record was reviewed on 12/22/25 at 10:01 a.m. The diagnoses included, but were not limited to, stroke, dementia, and diabetes.

The Service Plan, dated 12/9/25, indicated the resident required assistance with daily decision making. The Medication Assistance section indicated the resident would take their medications as directed by their prescriber.

A Physician's Order, dated 11/4/25, indicated to administer gabapentin 100 milligrams (mg) by mouth at 8:00 a.m. and 2:00 p.m. daily.

The November 2025 Medication Administration Record (MAR) indicated gabapentin was administered incorrectly on the following dates and times:

- 11/9/25 at 12:38 p.m.

- 11/10/25 at 11:23 a.m.

- 11/13/25 at 9:34 a.m.

- 11/14/25 at 9:08 a.m. and 11:18 a.m.

- 11/17/25 at 9:22 a.m.

- 11/18/25 at 9:37 a.m.

- 11/20/25 at 10:07 a.m. and 12:24 p.m.

- 11/21/25 at 9:06 a.m. and 12:11 a.m.

- 11/23/25 at 6:48 a.m. and 12:08 p.m.

A Physician's Order, dated 11/14/25, indicated Clotrimazole 1% cream was to be applied to the affected area twice a day.

A Nurse's Note, dated 11/20/25, at 10:39 a.m., indicated an order was received on 11/14/25 for Clotrimazole 1% cream to be applied to affected area of skin (red, itchy, moist folds) twice a day.

The November 2025 Medication Administration Record (MAR) indicated Clotrimazole was not given as ordered on the following dates:

- 11/14/25

- 11/15/25

- 11/16/25

- 11/17/25

- 11/18/25

- 11/29/25

During an interview on 12/23/25 at 10:22 a.m., the Executive Director indicated that the order in the November MAR was changed to morning and afternoon and was changed back on 12/1/25 to receive it at 8 :00 a.m. and 2:00 p.m. She indicated the QMA's were signing out their medication pass at the end of the pass and it looked like the resident was receiving medication too close together. She understood there was no way to prove the medication was not given at that time and had no further documentation to provide. She also indicated she could not recall why it took so long to receive the Clotrimazole, but was most likely due to a pharmacy delay.

This citation relates to Intake 466673.

Based on record review and interview, the facility failed to ensure medication was given as ordered for 1 of 3 residents reviewed for medication administration. (Resident B)

Finding includes:

Resident B's record was reviewed on 12/22/25 at 10:01 a.m. The diagnoses included, but were not limited to, stroke, dementia, and diabetes.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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