STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/31/2022

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 a Post Survey Revisit (PSR) to the Investigation of Complaint IN00390943 completed on September 26, 2022. Complaint IN00390943 - Corrected Survey date: October 31, 2022 Facility number: 010610 Residential Census: 64 Trail Creek Place - Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00390943. Quality review completed on 11/1/11. This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00390943 completed on September 26, 2022.	R 0000		

	Complaint IN00390943 - Corrected Survey date: October 31, 2022 Facility number: 010610 Residential Census: 64 Trail Creek Place - Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00390943. Quality review completed on 11/1/11.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.	R 0349		
R 0406	Infection Control - Offense 410 IAC 16.2-5-12(a)	R 0406		

	(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.			

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