

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/29/2025	
NAME OF PROVIDER OR SUPPLIER TRAIL CREEK PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 State Residential Licensure Survey. Survey dates: January 27, 28, and 29, 2025 Facility number: 010610 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/31/25.	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions outlined in this allegation by the survey agency.				
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within	R 0090	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The resident affected is no longer a resident of facility. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and	02/14/2025			

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

twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.	what corrective action will be taken: Residents had the potential to be affected by this allegedly deficient practice. Corrective action has been completed for residents who had potential to be affected, audit of incident logs completed, and no further residents were affected. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur: Executive Director (ED), Director of Nursing (DON) have access to the gateway for reporting. Education completed with ED and DON related to the process for Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Investigations will be scanned and saved to a secure file to prevent further occurrences. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing the incident report log and investigation electronic storage weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure that reporting requirements are met timely. The audit will be discussed monthly with Leadership. Monitoring will be ongoing unless deemed unnecessary by the Quality/Safety Committee.	
--	--	--

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

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on record review and interview, the facility failed to ensure an allegation of abuse incident was reported timely to the Indiana Department of Health (IDOH) and a thorough investigation was documented for 1 of 1 allegation of abuse reviewed. (Resident 8)

Finding includes:

Resident 8's record was reviewed on 1/28/25 at 10:34 a.m. Diagnoses included, but were not limited to, dementia and adult failure to thrive.

A Progress Note, dated 5/27/24, indicated Resident 8 was up for punch in the dining room. The resident was making false sexual allegations about male staff and male residents and false claims about staff of color stealing from her. Staff

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

attempted to re-direct the resident without success.

A Progress Note, dated 5/28/24, indicated Resident 8 was making false sexual allegations regarding male staff and male residents. The staff member tried talking to the resident about doing that, but the resident insisted that what she was saying had happened. The allegation would be reported to the Executive Director (ED).

During an interview on 1/28/25 at 2:45 p.m., the Executive Director (ED) indicated the allegations were reported to her and she had completed an investigation. She had interviewed staff about the allegations and was unable to substantiate the allegations. At the time, Resident 8 was having episodes of psychosis, multiple UTIs (urinary tract infections), and the family was looking at starting her under hospice care. She was having multiple medication changes to try to help with the psychosis as well. The ED had started a reportable to IDOH, but it was not submitted. She was unable to locate documentation of the investigation.

A facility policy titled, "Occurrence Reporting," received from the ED and noted as current, indicated, "1. All associates are responsible for

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

immediately reporting to a Leadership Team Member or the Executive Director any unusual occurrence which is unexpected, unintended, undesirable, or which departs from the routine operation of the community. 2. Unusual occurrences are those that directly threaten the welfare, safety, or health of a resident or residents. Unusual occurrences must be reported by every team included but not limited to: a. Abuse...i. Physical abuse...ii. Sexual abuse...iii. Verbal abuse...iv. Mental abuse...v. Involuntary seclusion...3. Upon receiving a report of an unusual occurrence, the Leadership Team Member or Executive Director will first ensure the resident's safety and wellbeing. a. The resident's condition will be assessed....b. In the event an associate, visitor, family member, vendor, or other person is accused of abuse...the individual will be asked to leave the property and asked to refrain from coming to the property until an investigation can be completed...c. In the event another resident is accused of abuse, neglect, mistreatment, or misappropriation of property or money, the residents will be separated, and every effort will be made to avoid contact with or access to the resident under investigation...4. The associate reporting the occurrence will

completed an Incident Report with the facts. This report should not be subjective or concluded but should only report on the occurrence as it was observed...7. The ED will report the incident via the ISDH Gateway within 24 hours...8. The ED or designee will complete an investigation of the occurrence..."

Based on record review and interview, the facility failed to ensure an allegation of abuse incident was reported timely to the Indiana Department of Health (IDOH) and a thorough investigation was documented for 1 of 1 allegation of abuse reviewed. (Resident 8)

Finding includes:

Resident 8's record was reviewed on 1/28/25 at 10:34 a.m. Diagnoses included, but were not limited to, dementia and adult failure to thrive.

A Progress Note, dated 5/27/24, indicated Resident 8 was up for punch in the dining room. The resident was making false sexual allegations about male staff and male residents and false claims about staff of color stealing from her. Staff attempted to re-direct the resident without success.

A Progress Note, dated 5/28/24, indicated Resident 8 was making false sexual allegations

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

regarding male staff and male residents. The staff member tried talking to the resident about doing that, but the resident insisted that what she was saying had happened. The allegation would be reported to the Executive Director (ED).

During an interview on 1/28/25 at 2:45 p.m., the Executive Director (ED) indicated the allegations were reported to her and she had completed an investigation. She had interviewed staff about the allegations and was unable to substantiate the allegations. At the time, Resident 8 was having episodes of psychosis, multiple UTIs (urinary tract infections), and the family was looking at starting her under hospice care. She was having multiple medication changes to try to help with the psychosis as well. The ED had started a reportable to IDOH, but it was not submitted. She was unable to locate documentation of the investigation.

A facility policy titled, "Occurrence Reporting," received from the ED and noted as current, indicated, "1. All associates are responsible for immediately reporting to a Leadership Team Member or the Executive Director any unusual occurrence which is unexpected, unintended, undesirable, or which departs

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

from the routine operation of the community. 2. Unusual occurrences are those that directly threaten the welfare, safety, or health of a resident or residents. Unusual occurrences must be reported by every team included but not limited to: a. Abuse...i. Physical abuse...ii. Sexual abuse...iii. Verbal abuse...iv. Mental abuse...v. Involuntary seclusion...3. Upon receiving a report of an unusual occurrence, the Leadership Team Member or Executive Director will first ensure the resident's safety and wellbeing. a. The resident's condition will be assessed....b. In the event an associate, visitor, family member, vendor, or other person is accused of abuse...the individual will be asked to leave the property and asked to refrain from coming to the property until an investigation can be completed...c. In the event another resident is accused of abuse, neglect, mistreatment, or misappropriation of property or money, the residents will be separated, and every effort will be made to avoid contact with or access to the resident under investigation...4. The associate reporting the occurrence will completed an Incident Report with the facts. This report should not be subjective or concluded but should only report on the occurrence as it was observed...7. The ED will report

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

	the incident via the ISDH Gateway within 24 hours...8. The ED or designee will complete an investigation of the occurrence..."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and	R 0217	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: One resident was affected by the deficient practice, evaluation and care plan was updated with dialysis and home health care services information immediately, oxygen was already documented on service plan. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:An audit has been conducted of other residents who could have been affected, no other residents were affected.3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:The Director of Nursing and Executive Director have been educated on the evaluation policy and procedure as it related to special services. Resident evaluations will be audited to ensure that special services are documented appropriately. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:The Executive Director is responsible for	02/14/2025

documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on observation, record review, and interview, the facility failed to ensure Service Plans were updated timely related to dialysis, home health services, and oxygen use for 1 of 7 resident records reviewed.
(Resident 3)

Finding includes:

During an interview on 1/27/25 at 1:45 p.m., Resident 3 indicated she handled all of her own medications, appointments, transportation to and from dialysis, and anything else. A large bandage was observed on her left upper arm covering a fistula dialysis access site. She had a portable oxygen tank that was running at 2 liters per minute through a nasal cannula.

The record for Resident 3 was reviewed on 1/27/25 at 11:00 a.m. Diagnoses included, but were not limited to, end stage renal disease, diabetes mellitus, and chronic obstructive

sustained compliance. The ED/designee will complete audits by reviewing the updated resident evaluations/care plans weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure that all special services are documented timely. The audit will be discussed monthly with Leadership. Monitoring will be ongoing unless deemed unnecessary by the Quality/Safety Committee.

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

pulmonary disease (COPD).
The resident was admitted to
the facility on 1/16/24.

The January 2025 Physician
Order Summary indicated the
resident went to dialysis three
times a week (Monday,
Wednesday, and Friday) and
received oxygen at 2 liters per
minute via a nasal cannula.

A Progress Note, dated
8/8/2024 at 11:46 a.m.,
indicated the resident was
starting physical and
occupational services (PT/OT).

The Service Plan, dated
11/9/24, indicated the resident
was cognitively intact with no
memory impairment. The
resident was able to
self-administer all medications
and completed all of her
activities of daily living (ADLs)
without assistance. The chronic
condition section indicated
dialysis. The Service Plan did
not include oxygen, home
health services, or any
information related to dialysis.

During an interview on 1/29/25
at 9:00 a.m., the Executive
Director indicated the resident
took care of all of her dialysis
needs including medications,
appointments, and
transportation. The facility had
communication with the dialysis
center for medication changes
and any status updates,

however everything else went thru the resident. The Service Plan should have addressed the oxygen and dialysis information. PT/OT services were not added to service plans.

Based on observation, record review, and interview, the facility failed to ensure Service Plans were updated timely related to dialysis, home health services, and oxygen use for 1 of 7 resident records reviewed. (Resident 3)

Finding includes:

During an interview on 1/27/25 at 1:45 p.m., Resident 3 indicated she handled all of her own medications, appointments, transportation to and from dialysis, and anything else. A large bandage was observed on her left upper arm covering a fistula dialysis access site. She had a portable oxygen tank that was running at 2 liters per minute through a nasal cannula.

The record for Resident 3 was reviewed on 1/27/25 at 11:00 a.m. Diagnoses included, but were not limited to, end stage renal disease, diabetes mellitus, and chronic obstructive pulmonary disease (COPD). The resident was admitted to the facility on 1/16/24.

The January 2025 Physician Order Summary indicated the resident went to dialysis three

times a week (Monday, Wednesday, and Friday) and received oxygen at 2 liters per minute via a nasal cannula.

A Progress Note, dated 8/8/2024 at 11:46 a.m., indicated the resident was starting physical and occupational services (PT/OT).

The Service Plan, dated 11/9/24, indicated the resident was cognitively intact with no memory impairment. The resident was able to self-administer all medications and completed all of her activities of daily living (ADLs) without assistance. The chronic condition section indicated dialysis. The Service Plan did not include oxygen, home health services, or any information related to dialysis.

During an interview on 1/29/25 at 9:00 a.m., the Executive Director indicated the resident took care of all of her dialysis needs including medications, appointments, and transportation. The facility had communication with the dialysis center for medication changes and any status updates, however everything else went thru the resident. The Service Plan should have addressed the oxygen and dialysis information. PT/OT services were not added to service plans.

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

FORM APPROVED

OMB NO. 0938-0391

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
---	-------	-----------