STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/07/2025

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 a State Residential Licensure Survey. Survey dates: October 6 and 7, 2025 Facility number: 010610 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/14/25.	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 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall	R 0092	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the deficient practice.2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what	10/24/2025

	include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure the fire department was invited to attend fire drills every six months. This had the potential to affect all 73 residents residing in the facility. Finding includes: On 10/6/25 at 2:05 p.m., the monthly fire drill records were reviewed for the past twelve months. The records included the date, time and participants of the drills. There was no indication the fire department had been invited to or had		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; Michigan City Fire Department has been contacted and invited to participate in the TCP fire drill on November 5, 2025.3. 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), and Maintenance Director (MD) will invite the fire department to participate in fire drills at least two times per year and document their invitation and/or participation fire drill documents.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 audit fire drills monthly for one year to ensure sustained compliance.	

participated in any of the drills.

During an interview on 10/7/25 at 1:20 p.m., the Maintenance Director indicated the fire department had been out recently for an actual problem in the facility, not a drill. He had not invited the fire department to participate in any drills in the last 12 months.

Based on record review and interview, the facility failed to ensure the fire department was invited to attend fire drills every six months. This had the potential to affect all 73 residents residing in the facility.

Finding includes:

On 10/6/25 at 2:05 p.m., the monthly fire drill records were reviewed for the past twelve months. The records included the date, time and participants of the drills. There was no indication the fire department had been invited to or had participated in any of the drills.

During an interview on 10/7/25 at 1:20 p.m., the Maintenance Director indicated the fire department had been out recently for an actual problem in the facility, not a drill. He had not invited the fire department to participate in any drills in the last 12 months.

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 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	R 0217	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	10/24/2025

	nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure a resident's service plan was up to date related to insulin use and glucometer (machine used to measure blood sugar levels) checks for 1 of 7 residents reviewed. (Resident 2) Finding includes: Resident 2's record was reviewed on 10/6/25 at 10:57 a.m. Diagnoses included, but were not limited to, acute renal failure and diabetes mellitus. The current October 2025 Physician Order Summary indicated insulin lispro 100 unit/milliliter inject before meals per the sliding scale: 0 - 149: 0 unit (u), 150 - 199: 1 u, 200 - 249: 2 u, 250 - 299: 3 u, 300 - 349: 4 u, and 350 - 400: 5 u. The Service Plan, dated 9/9/25, indicated the resident was cognitively intact and required caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect. The section "Medication Procedures: insulin injections administered per caregiver		One resident was affected by the deficient practice; evaluation and care plan was updated with insulin administration and blood sugar checks immediately.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 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 been educated by corporate clinical on the evaluation policy and procedure 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 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.	

	and/or fingerstick glucose monitoring at least one time per day," was not marked. During an interview on 10/7/25 at 1:12 p.m., the Executive Director indicated the resident received glucometer checks and insulin administration and that should have been marked on the service plan. Based on record review and interview, the facility failed to ensure a resident's service plan was up to date related to insulin use and glucometer (machine used to measure blood sugar levels) checks for 1 of 7 residents reviewed. (Resident 2) Finding includes: Resident 2's record was reviewed on 10/6/25 at 10:57 a.m. Diagnoses included, but were not limited to, acute renal failure and diabetes mellitus. The current October 2025 Physician Order Summary indicated insulin lispro 100 unit/milliliter inject before meals per the sliding scale: 0 - 149: 0 unit (u), 150 - 199: 1 u, 200 - 249: 2 u, 250 - 299: 3 u, 300 - 349: 4 u, and 350 - 400: 5 u. The Service Plan, dated 9/9/25, indicated the resident was cognitively intact and required caregiver administration and/or			

	observation of medications requiring judgment for necessity, dosage and/or effect. The section "Medication Procedures: insulin injections administered per caregiver and/or fingerstick glucose monitoring at least one time per day," was not marked. During an interview on 10/7/25 at 1:12 p.m., the Executive Director indicated the resident received glucometer checks and insulin administration and that should have been marked on the service plan.			
R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on record review and interview, the facility failed to ensure insulin was not administered by QMAs (Qualified Medication Aide) without insulin administration certifications for 2 of 7 residents reviewed. (Residents 2 and 3) Findings include: 1. Record review for Resident 2 was completed on 10/6/25 at 10:57 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and acute renal failure	R 0245	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Two residents were affected by the deficient practice in regard to improper charting by a QMA for insulin administration.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 other residents who could have been affected; no other residents have been 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 educated all QMA’s on proper documentation as it applies to insulin	10/24/2025

	The October 2025 Physician's Order Summary (POS) indicated an order for the following medication: - Insulin lispro, inject twice daily before breakfast and dinner per sliding scale: 0 UNIT (0 - 149), 1 UNIT (150 - 199), 2 UNIT (200 - 249), 3 UNIT (250 - 299), 4 UNIT (300 - 349), 5 UNIT (350 - 400) The August 2025 Medication Administration Record (MAR) indicated the insulin lispro was administered by unqualified QMA 1 before dinner on the following dates: - 1 unit on 8/11/25, 2 units on 8/12/25, 1 unit on 8/13/25, 2 units on 8/17/25, 1 unit on 8/19/25, 1 unit on 8/20/25, 1 unit on 8/25/25, and 4 units on 8/31/25 The September 2025 Medication Administration Record (MAR) indicated the insulin lispro was administered by unqualified QMA 1 before dinner on the following dates: - 2 units on 9/2/25, 2 units on 9/3/25, 4 units on 9/8/25, 3 units on 9/9/25, 3 units on 9/10/25, 4 units on 9/14/25, 3 units on 9/16/25, 4 units on 9/17/25, 2 units on 9/22/25, 1 unit on 9/24/25, and 3 units on 9/28/25 Facility certification documentation did not indicate		administration. QMA's will not document the administration of insulin given by staff nurses, DON or ED.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 current MAR for all residents receiving insulin weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure that all insulin administrations are documented properly. The audit will be discussed monthly with Leadership. Monitoring will be ongoing unless deemed unnecessary by the Quality/Safety Committee.	

that QMA 1 was certified to administer insulin.

During an interview on 10/7/25 at 1:12 p.m., the Executive Director indicated they were having problems with their charting system and it was allowing QMAs to document they had given insulin, however she believed that the QMA was not actually administering the insulin.

2. Resident 3's record was reviewed on 10/7/25 at 2:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and chronic kidney disease.

The October 2025 Physician's Order Summary indicated insulin lispro 100 unit/milliliter before breakfast, lunch, and dinner per sliding scale: 0 UNIT (0 - 149), 4 UNIT (150 - 199), 8 UNIT (200 - 249), 10 UNIT (250 - 299), 14 UNIT (300 - 349), 18 UNIT (350 - 400).

The September 2025 Medication Administration Record indicated the insulin lispro was administered by unqualified QMA 1 before dinner on the following dates:

- 4 units on 9/2/24, 4 units on 9/3/25, 8 units on 9/8/25, 8 units on 9/9/25, 8 units on 9/10/25, 4 units on 9/14/25, 8 units on 9/16/25, 4 units on 9/17/25, 4 units on 9/22/25, 8 units on

9/24/25, and 4 units on 9/28/25

The October 2025 Medication Administration Record indicated 2 units of insulin lispro were administered by unqualified QMA 1 before dinner on 10/6/25.

Facility certification documentation did not indicate that QMA 1 was certified to administer insulin.

During an interview on 10/7/25 at 1:12 p.m., the Executive Director indicated they were having problems with their charting system and it was allowing QMAs to document they had given insulin, however she believed that the QMA was not actually administering the insulin.

Based on record review and interview, the facility failed to ensure insulin was not administered by QMAs (Qualified Medication Aide) without insulin administration certifications for 2 of 7 residents reviewed. (Residents 2 and 3)

Findings include:

1. Record review for Resident 2 was completed on 10/6/25 at 10:57 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and acute renal failure

The October 2025 Physician's Order Summary (POS)

indicated an order for the following medication:

- Insulin lispro, inject twice daily before breakfast and dinner per sliding scale: 0 UNIT (0 - 149), 1 UNIT (150 - 199), 2 UNIT (200 - 249), 3 UNIT (250 - 299), 4 UNIT (300 - 349), 5 UNIT (350 - 400)

The August 2025 Medication Administration Record (MAR) indicated the insulin lispro was administered by unqualified QMA 1 before dinner on the following dates:

- 1 unit on 8/11/25, 2 units on 8/12/25, 1 unit on 8/13/25, 2 units on 8/17/25, 1 unit on 8/19/25, 1 unit on 8/20/25, 1 unit on 8/25/25, and 4 units on 8/31/25

The September 2025 Medication Administration Record (MAR) indicated the insulin lispro was administered by unqualified QMA 1 before dinner on the following dates:

- 2 units on 9/2/25, 2 units on 9/3/25, 4 units on 9/8/25, 3 units on 9/9/25, 3 units on 9/10/25, 4 units on 9/14/25, 3 units on 9/16/25, 4 units on 9/17/25, 2 units on 9/22/25, 1 unit on 9/24/25, and 3 units on 9/28/25

Facility certification documentation did not indicate that QMA 1 was certified to administer insulin.

During an interview on 10/7/25 at 1:12 p.m., the Executive Director indicated they were having problems with their charting system and it was allowing QMAs to document they had given insulin, however she believed that the QMA was not actually administering the insulin.

2. Resident 3's record was reviewed on 10/7/25 at 2:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and chronic kidney disease.

The October 2025 Physician's Order Summary indicated insulin lispro 100 unit/milliliter before breakfast, lunch, and dinner per sliding scale: 0 UNIT (0 - 149), 4 UNIT (150 - 199), 8 UNIT (200 - 249), 10 UNIT (250 - 299), 14 UNIT (300 - 349), 18 UNIT (350 - 400).

The September 2025 Medication Administration Record indicated the insulin lispro was administered by unqualified QMA 1 before dinner on the following dates:

- 4 units on 9/2/24, 4 units on 9/3/25, 8 units on 9/8/25, 8 units on 9/9/25, 8 units on 9/10/25, 4 units on 9/14/25, 8 units on

	9/16/25, 4 units on 9/17/25, 4 units on 9/22/25, 8 units on 9/24/25, and 4 units on 9/28/25 The October 2025 Medication Administration Record indicated 2 units of insulin lispro were administered by unqualified QMA 1 before dinner on 10/6/25. Facility certification documentation did not indicate that QMA 1 was certified to administer insulin. During an interview on 10/7/25 at 1:12 p.m., the Executive Director indicated they were having problems with their charting system and it was allowing QMAs to document they had given insulin, however she believed that the QMA was not actually administering the insulin.			

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 SIGNATUREChristy Miller	TITLEExecutive Director	(X6) DATE10/23/2025