STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRAIL CREEK PLACE- ASSISTED LIVING	1400 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00418499. Complaint IN00418499 - State deficiencies related to the allegations are cited at R0090 and R0406. Survey dates: October 10 and 11, 2023 Facility number: 010610 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/13/23.	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 set forth in this allegation by the survey agency.*	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (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 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:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy Miller	Executive Director	10/27/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	(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. (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 report a COVID-19 outbreak in the facility to the Indiana Department of Health (IDOH) in a timely manner. This had the potential to affect all 54 residents residing in the facility.	R 0090	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	10/27/2023

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	Finding includes: Review of the facility's COVID-19 line listing was completed on 10/10/23 at 11:16 a.m. The line listing had 4 staff members and 7 residents who were recently COVID positive. The line listing indicated: - 9/10/23: 1 staff member COVID positive - 9/22/23: 1 resident COVID positive - 9/23/23: 1 resident COVID positive - 9/25/23: 2 residents COVID positive - 9/27/23: 1 resident COVID positive - 9/30/23: 1 resident COVID positive - 10/2/23: 3 staff members COVID positive - 10/3/23: 1 resident COVID positive There was no documentation to indicate the facility's COVID-19 outbreak had been reported to IDOH. Interview with the Administrator on 10/10/23 at 3:14 p.m., indicated she had problems getting into the IDOH Gateway to report the outbreak. The facility had recently changed names and she was unable to use the Gateway. She did not think about faxing the facility outbreak to IDOH since she was unable to use the Gateway. She was able to use the IDOH Gateway on 10/6/23, but did not send the reportable outbreak in then. She would send in the reportable today. This citation relates to Complaint IN00418499.		The COVID-19 outbreak report was made on 10/11/2023. No residents are affected by this practice. **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:** All residents had the potential to be affected by this deficient practice. Corrective action has been completed for all residents who had potential to be affected, audit of infection control 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), Assisted Living Director of Nursing (AL DON) and Memory Care Director of Nursing (MC DON) now have access to the gateway for all reporting requirements. Education completed with ED, AL DON and MC DON on 10/12/23 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	

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			health of a resident. **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 infection control log weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure that all reporting requirements are met timely. The audit willbe discussed monthly. Monitoring will be ongoing. **5. By what date will the systemic changes be completed?** 10/27/2023	
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form to meet individual needs related to incorrectly made pureed food. This had the	R 0270	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	10/27/2023

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	potential to affect 6 residents who received a pureed diet. (Memory Care Kitchen, Cook 2) Finding includes: On 10/11/23 at 11:45 a.m., Cook 2 was observed preparing a pureed mixed vegetable. Cook 2 added 4 cups of vegetables to the mixer and turned the mix cycle on. The vegetables went through one full cycle of mixing and was completed. A thinner was not added. The completed pureed vegetables had chunks of carrots in the mixture. Cook 2 poured pureed vegetables into a bowl and covered the top with aluminum foil. The bowl of vegetables was then added to the heated grill. On 10/11/23 at 12:05 a.m., Cook 2 indicated she was finished with pureed meal preparation; the recipes were completed. Food temperatures were ready to be checked and then the food would be served. At that time, the pureed food was observed to be thick, with chunks of carrot in the mixture. On 10/11/23 at 12:08 a.m., Cook 2 was observed during a second mixing attempt. Broth was used to thin the recipe. After second mixing attempt the vegetables were at an appropriate mashed potato consistency. Interview with Cook 2 on 10/11/23 at the time, indicated that she should have thinned the vegetable mixture initially to break down the carrots more. Interview with Administrator on 10/11/23 at 12:30 p.m., indicated Cook 2 should have added thinner to the recipe and acknowledged the chunks in the completed meal.		**practice:** No residents were affected by this practice. The 6 residents that had potential to be affected were not served the pureed vegetables that were observed to have chunks in it. **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:** Diet orders are posted for staff and special diets will be audited prior to being served. **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 Dining Service Director (DSD) and all cooks will be educated by the ED on the policy and procedure for pureed food preparation and use of pureed recipes. Regional dining services director to educate dining staff on proper preparation of altered diets. **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	

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	A recipe titled; "Pureed Mixed Vegetables" was provided by Cook 2 on 10/11/23 at 12:33 p.m. This current recipe indicated, " ... If the product needs thinning, gradually add an appropriate amount of liquid (NOT WATER) to achieve a smooth, pudding or soft mashed potato consistency..."		responsible for sustained compliance. The ED/designee will complete audits 3x weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure pureed foods are at the appropriate consistency. The audit willbe discussed monthly. Monitoring will be ongoing. **5. By what date will the systemic changes be completed?** 10/27/2023	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to maintain proper hygiene related to beard guards not properly worn during food preparation. This had the potential to affect 32 residents in Assisted Living who received food from the Main Kitchen. (Main Kitchen, Cook 1) Finding includes: On 10/10/23 at 8:38 a.m., Cook 1 was observed in the kitchen preparing breakfast. He was not wearing a beard guard. On 10/10/23 at 9:06 a.m., Cook 1 was observed holding a plate of cooked eggs for a resident with his inch long beard exposed. Interview with Dietary Manager (DM) on 10/11/22 at 9:18 a.m., indicated that he was so busy in the	R 0273	**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 this. **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:** All cooks and DSD were educated by ED on 10/10/23 of the policy and procedure for hair restraints prior to the next meal being served (lunch). **3. What measure will be put**	10/27/2023

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	kitchen he didn't realize that Cook 1 wasn't wearing a beard guard. Bearded staff were expected to wear a beard guard while in the kitchen. Interview with the Administrator on 10/11/22 at 9:22 a.m., indicated that Cook 1 should have been wearing a beard guard. A policy titled; "Hair Restraints" was provided by the Administrator on 10/10/23 at 11:24 a.m. This current policy indicated, " ... Staff shall wear hair restraints in all food preparation and serving areas. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food."		**into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** All cooks and DSD will be educated on policy and procedure for hair restraints. **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 observing cooks for proper hair restraints 3x weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure proper hair restraints. The audit willbe discussed monthly. Monitoring will be ongoing. **5. By what date will the systemic changes be completed?** 10/27/2023	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or			

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	date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the resident Emergency Binders contained all the necessary information for 2 of 5 residents reviewed. (Residents 3 and B) Findings include: The resident Emergency Binders were reviewed on 10/11/23. The following information was missing: a. Resident 3 was missing hospital preference, physician and physician's phone number, and a section for allergies. b. Resident B was missing physician and physician's phone number. Interview with the Administrator on 10/11/23 at 11:38 a.m., indicated she would get the records for those residents updated.	R 0356	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The 2 residents identified had their emergency information updated 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:** All residents had the potential to be affected by this deficient practice. The AL and MC DON have audited remaining emergency binder to ensure complete and accurate information. **3. What measure will be put into place or what systemic changes the facility will make**	10/27/2023

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			to ensure that the deficient practice does not reoccur: All current residents' face sheets will be updated on new documents and placed in the emergency binder to ensure accurate records. All new admissions will utilize the new face sheet and DON will ensure a copy is placed in the emergency binder. AL and MC DON re-educated on emergency information file requirements. **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 all new residents face sheets and current emergency binder weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure records are complete. The audit willbe discussed monthly. The audit willbe discussed monthly. Monitoring will be ongoing. **5. By what date will the systemic changes be completed?** 10/27/2023	

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R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (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. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and or contain COVID -19, related to COVID positive residents not in isolation for the recommended time period and staff not knowledgeable about isolation laundry procedures. This had the potential to affect 22 residents who resided in the Memory Care building. Findings include: 1. On 10/11/23 at 11:05 a.m., Resident B's room was observed. There were no isolation signs posted on his door and there was no PPE (personal protective equipment) bin outside his doorway. Resident B's record was reviewed on 10/11/23 at 10:40 a.m. Diagnoses included, but were not limited to, dementia and anxiety. A Progress Note, dated 10/3/23 at 7:00 a.m., indicated the resident had a temperature of 102.1 F (Fahrenheit) and displayed signs and symptoms of COVID. A test was completed, and the results were positive for COVID. Contact and droplet isolation was initiated. A Progress Note, dated 10/10/23, indicated the resident was out of isolation and had no signs or	R 0406	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All residents who were positive for COVID-19 during this outbreak have resolved at this time. **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:** The residents who had potential to be affected were observed for any s/sx of COVID-19, no further illness noted at this time. **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:** ED, AL DON and MC DON re-educated on resident isolation requirements and laundry procedure related to COVID-19 isolation. All staff will be educated on COVID-19 isolation guidelines and procedure for handling laundry	10/27/2023

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	symptoms of infection. The Memory Care COVID-19 Infection Control Log, indicated the resident had a cough and temperature. He had tested positive for COVID on 10/3/23 and completed 7 days in isolation on 10/10/23. Interview with the Memory Care Director of Nursing (DON) on 10/11/23 at 10:57 a.m., indicated when they had the first COVID positive resident she had spoken to the Administrator who had indicated per corporate the isolation for any COVID positive residents was 7 days. 2. The Memory Care COVID-19 Infection Control Log was reviewed on 10/11/23 at 10:30 a.m. and indicated the following: Resident C had a runny nose and cough. She tested positive for COVID on 9/23/23 and completed 7 days in isolation on 9/30/23. Resident D had a cough and aches. She tested positive for COVID on 9/25/23 and completed 7 days in isolation on 10/2/23. Resident E had a cough and body aches. He tested positive for COVID on 9/25/23 and completed 7 days in isolation on 10/2/23. Resident F had a runny nose and cough. He tested positive for COVID on 9/27/23 and completed 7 days in isolation on 10/4/23. Resident G had a cough and runny nose. He tested positive for COVID on 9/30/23 and completed 7 days in isolation on 10/7/23. Interview with the Administrator on 10/11/23 at		during COVID-19 isolation. PPE will be supplied in all laundry areas for staff use. **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 observing isolation and laundry guidelines are being followed 3x/week during any future COVID-19 outbreaks x 3 months to ensure proper isolation and laundry procedures. The audit willbe discussed monthly. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** 10/27/2023	

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	11:33 a.m., indicated when the facility had the first COVID positive resident she had reached out to her corporate for guidance. She was told to follow the local health department's guidance. The local health department hadn't provided any guidance and she was told to follow the current CDC (Centers for Disease Control and Prevention) guidance. She had looked on the CDC website and was only able to find the guidance for COVID positive health care workers, which was 7 days, so that is what she followed. She indicated the facility had no specific policy for isolation of COVID positive residents. A current facility policy, titled "Infectious Disease Outbreak Policy & Procedures", indicated, "...Preventing Spread/Containing Illness:...Read local health departments of CDC's website for informational updates. In an effort to prevent the spread of the illness the Community will:...Encourage any ill Resident to refrain from attending activities and/or meals in the dining room and to remain in their apartment for at least 24 hours (or as recommended by health authorities) after the symptoms have resolved..." Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, per the CDC's website, updated 5/8/23, indicated "...Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection...Patients with mild to moderate illness who are not moderately to severely immunocompromised: At least 10 days have passed since symptoms first appeared and at least 24 hours have passed since last fever without the use of fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved. Patients who were asymptomatic throughout their			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRAIL CREEK PLACE- ASSISTED LIVING	1400 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	infection and are not moderately to severely immunocompromised: at least 10 days have passed since the date of their first positive viral test..." 3. Interview with CNA 1 on 10/11/23 at 11:11 a.m., indicated the residents' clothes would be placed in a black garbage bag if they had COVID or were in isolation. She would wear gloves when she handled and completed the laundry. She was unsure if they needed to wear anything other than gloves or if there was a policy. Interview with the Administrator on 10/11/23 at 11:29 p.m., indicated there was not a current policy in place for PPE required for staff to wear while doing laundry for residents with COVID. Interview with Memory Care Director of Nursing (DON) on 10/11/23 at 1:39 p.m., indicated the staff was expected to wear appropriate PPE when doing laundry for resident's with COVID. The expectation would be the same as caring for a COVID positive resident. This citation relates to Complaint IN00418499.			