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	09/26/2022

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00390943. Complaint IN00390943 - Substantiated. State deficiencies related to the allegations are cited at R0349 and R0406. Survey date: 9/26/22 Facility number: 010610 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 29, 2022.	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 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (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. Based on observation, interview, and record review, the facility failed to ensure clinical records	R 0349	=”” b=””> =”” p=””> **1. What corrective action(s) will**	10/26/2022

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

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	were complete and accurately documented related to reportable incident investigations for 2 of 2 incidents reviewed. (Residents D and E) Findings include: 1. On 9//26/22 at 11:15 a.m., Resident D was observed being wheeled into the dining room in a Broda chair. There was a soft cast with an ace wrap noted to her left lower leg. While at the dining room table, she was observed to have intermittent loud verbalizations and occasional restless movements. Resident D's record was reviewed on 9/26/22 at 12:00 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, bipolar disorder, neuropathy, restless leg syndrome & delusional disorder. A "State Reportable Binder" included a single typed sheet for Resident D which indicated the following: "Actual or identified date and time of incident: 8/31/22 07:30 a.m. Residents involved: [Resident D's name] Staff involved: none Brief description: Memory Care resident had an unwitnessed fall from her wheelchair and was observed laying on the floor on her back in the dining room. Type of injury: Left tibial fracture Immediate action: The resident was assessed by nurse and noted some redness to the lower left extremity. Family and PCP [primary care provider] notified. Preventative measures taken: Mobility assessment updated Follow-up: Hospice notified of the residents' [sic] fall and came to assess the resident. Order for an		**be accomplished for those residents found to have been affected by the deficient practice:** The clinical record for resident B was updated on 10/10/22 by the Care Services Manager (CSM) with documentation indicating how the injury likely occurred. The clinical record for resident C was updated on 10/10/22 by the CSM with documented analysis of the incident. **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 of clinical records for residents with reportable incidents in the last 90 days was completed on 10/10/22 by the Regional Care Specialist to ensure clinical records are complete and accurately documented related to reportable incident investigations. No concerns identified. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The CSM was retrained on 10/10/22 by the Regional Director of Care Services to ensure clinical records are complete and accurately documented related to	

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	x-ray received. X-ray results show a left tibial fracture. The family requested the resident be transported to the ER for evaluation. The resident to follow-up with an orthopedic surgeon. The plan of care will be updated." Resident Service Notes indicated the following: On 8/31/22 at 10:00 a.m., the resident was observed laying on the floor in the dining room. No injury was noted. Vital signs were within normal limits (WNL). The Power of Attorney (POA), physician, Hospice, Care Services Manager (CSM) & Executive Director (ED) were notified. On 8/31/22 at 11:30 a.m., bruising was noted to the resident's left lower leg. The Nurse Practitioner (NP) was notified, and new orders were received for a stat x-ray. On 8/31/22 at 3:10 p.m., the resident was sent to the local emergency room (ER) via ambulance per the POA's request. Hospice was notified. On 8/31/22 no time noted, the resident returned at 6:50 p.m. via ambulance. The ER nurse reported a left tibia/ fibula (lower leg) fracture which was wrapped in a soft cast. The family opts to not intervene with surgery, but to manage pain. There was no further investigation or documentation in the binder or the resident's chart related to how the injury could have occurred. An initial reportable incident was received by IDOH (Indiana Department of Health) on 9/1/22 but no follow up was received. An interview with the CSM on 9/26/22 at 12:45 p.m. indicated she did not have a written		reportable incident investigations. **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:** Effective 10/24/22, the CSM or designee will complete an audit of clinical records for residents with reportable incidents to ensure clinical records are complete and accurately documented related to reportable incident investigations. The audit will occur weekly x 4 weeks, the bi-weekly x 4 weeks, then monthly. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance of 100%. Monitoring will be on-going.	

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	investigation. She had been present with Registered Nurse (RN) 1 at the time of the incident they had both heard the resident making loud noises and found her on the dining room floor around 7 or 7:30 a.m. So, the documentation time of 10:00 a.m. in the resident's chart must have been late charting not identified as such. She indicated prior to her fall, Resident D had used a regular wheelchair and could wheel herself around independently. She was restless at times and also had a habit of putting her foot up on the table and rocking. They had checked the table after the fall, and nothing was observed. There were no other residents in the dining room at the time the resident was found. She had interviewed other staff, and no one had seen anything other than the resident in the dining room. Resident D had been switched from a regular wheelchair to a Broda chair after her return to the facility. An interview with RN 1 on 9/26/22 at 2:20 p.m. indicated she was present at the time of Resident D's fall. She was getting medications ready and heard the resident making louder than usual verbalizations. She found the resident on the floor in the corner of the dining room near a table with her wheelchair a little ways away from her and the CSM assisted. There was no one else in the dining room at the time and only one other resident observed sitting on the couch in the next room. RN 1 indicated the wheelchair was not locked when they moved it to help the resident. Resident D did have a tendency to put her feet up on the table and push at times. She had never witnessed any other resident pushing Resident D's wheelchair. 2. On 9/26/22 at 10:40 a.m., Resident C was observed sitting in a wheelchair in the dining area with other residents. There were no behaviors or			

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	exit-seeking noted. Resident C's record was reviewed on 9/26/22 at 10:28 a.m. Diagnoses included, but were not limited to, Alzheimer's. Resident Service Notes indicated the following: On 9/5/22 at 10:00 p.m., the resident eloped from the building and was returned safely by staff. No injury was noted, and the resident had no complaints. The family and doctor were notified. Elopement Documentation, dated 9/5/22, indicated the following: - responded immediately and returned resident to community - resident was immediately located - Panel indicated C hall exterior door alarm A "State Reportable Binder" included a single typed sheet labeled, "Reportable Worksheet", for Resident C which indicated the following: "Actual or identified date and time of incident: 9/5/22 7:00 p.m. Residents involved: [Resident C name, room #, and age] Dx. [diagnoses]: dementia Staff involved: none Brief description: Aides responded to the south side door alarm where they found the Memory Care resident had gone out the exterior door. The aides immediately brought the resident back inside. Type of injury: none Immediate action: Resident assessed by nurse for injuries. Executive Director and POA [power of attorney] notified. Preventative measures taken: One-on-one staff with resident Follow-up: Care plan updated. Staff educated on			

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	door alarms and response time." Also included in the binder was an Elopement Documentation form which evaluated the elopement response with check boxes, completed but unsigned. There was no further investigation or documentation in the binder or the resident's chart related to an analysis of the incident. An interview with the Care Services Manager (CSM) on 9/26/22 at 10:50 a.m. indicated, prior to the resident's elopement, there were no exit seeking behaviors. On the evening of the event, they had just finished supper, there were 4 CNA's and a QMA working in the Memory Care building - one was on break, 2 were providing resident care, and the QMA was passing medications. When the alarm sounded, the aide looked at the alarm panel and saw the light indicated C hall. She went to the door exit, looked out, and didn't see the resident. The alarm was still going off, so she realized it was the other exit door down the hall. The resident was right outside the door and was immediately brought back inside. The facility had since renamed the doors on the alarm panel to be more specific. There had been no other recent elopements and no problems with the door alarms. Maintenance checks them regularly and elopement drills were completed. Follow up interview with the CSM on 9/26/22 at 12:45 p.m. indicated she did not have any written investigation documentation related to the incident. An initial reportable incident was received by IDOH (Indiana Department of Health) on 9/7/22 but no follow up was received.			

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	A facility policy titled, "Abuse, neglect and Exploitation," was presented as current on 9/26/22 at 2:00 p.m. The CSM indicated this was the policy the facility was to follow for all reportable incidents, not just abuse. The policy indicated, the contents of the follow up report (within 5 working days after the initial) were to include the results of the investigation, interventions implemented or corrective action taken, method in which the facility will continue to monitor the efficacy or the plan or interventions, and other persons or agencies to which the incident was reported. Directives for investigation and document retention indicated the community shall initiate an investigation and document the following as soon as practicable: dates, times and description of the event; a description of any injuries related to the incident and any changes to the resident; names of any witnesses; copies of any reports made to state agencies; and actions taken to prevent recurrence. A facility policy titled, "Elopement or Missing Resident," was presented as current by the CSM on 9/26/22 at 2:00 p.m. The policy indicated, post event, the ED (executive Director) and CSM should review the event with the team and discuss resident risk, implementation of risk reducing interventions. ad documents on Care Plan and Resident Service Notes. In addition, the ED, CSM or designee should ensure all notifications and documentation has been completed per the company policy and local/ state regulations. This state residential finding relates to Complaint IN00390943.			

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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 record review and interview, the facility failed to monitor, track, educate and implement precautions to prevent the spread of an identified communicable condition among residents and staff, resulting in an outbreak which had the potential to affect 27 of 27 residing in the Memory Care building and had the potential to expose 66 residents residing at the facility. Finding includes: The Infection Control binder was reviewed on 9/26/20 at 2:13 p.m. There were no residents with skin conditions recorded for September 2022 and only 1 resident recorded for August 2022, with a rash to the back and chest documented on 8/25/22 and medication ordered. A list of residents with skin issues in the last 90 days, presented by the Care Services Manager (CSM) upon request after the entrance conference on 9/26/22, included 6 resident names. Two of the residents listed had scabies or possible scabies identified. Three of the remaining 6 residents had general dermatitis indicated and the sixth resident had folliculitis listed and had been recorded in the Infection Control Binder. During a review of Resident D's chart on 9/26/22 at 10:50 a.m., the following was documented in the Resident Service Notes related to skin issues: - 8/22/22 admission note - rash present to the	R 0406	=”” b=””> Resident D, Staff 1, Staff 3, housekeeping, and the maintenance director were treated for scabies on or before 10/4/2022. 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:** A skin assessment of current residents was completed on 9/27/2022 by the CSM to identify residents with skin issues. The assessment results were reviewed with community nurse practitioner on 9/27/2022 by the CSM with orders received to treat current memory care residents for scabies. Treatment completed on 10/4/2022. No AL residents identified. Current memory care staff were assessed by community nurse practitioner on 9/27/2022 and prescribed treatment for scabies. Treatment of current staff completed by 10/6/2022 and staff permitted to return to work post treatment.	10/26/2022

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	middle of the back - 8/25/22 4:00 p.m. - New order received for permethrine cream 5%, apply to lower back once daily for 7 days, then twice weekly for 7 days. - 8/26/22 9:00 p.m. - First dose of permethrine cream applied to back, chest, & arms for rash. - 9/10/22 12:00 p.m. - Permethrine cream applied to the resident from neck to toes. POA (power of attorney) present. There was no listed diagnosis of scabies for Resident D and no documentation indicating any precautions were put in place to prevent transmission. An interview with the CSM, on 9/26/22 at 12:35 p.m., indicated she had not been tracking skin issues in the Infection Control Binder. Resident D had been admitted in August from another facility with a rash. The POA indicated it was scabies, the former facility had an outbreak, and she had brought cream to use. The facility contacted the physician for permission to use it and implemented contact precautions "as best as we could in Memory Care." The rash was observed on her back. One other resident presented with a rash "about a month ago" and was treated with cream. Currently, 8 additional residents had been identified with a rash as of 9/26/22 and they had yet to notify the Nurse Practitioner. The CSM indicated she had in-serviced staff on contact precautions, application of the cream, signs & symptoms of scabies, cleaning procedures and had asked the Maintenance Director to "spray those rooms." There was no documentation of any orders, signage, or education related to scabies, contact precautions, or in-services having been completed.		3 **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**: The CSM was retrained on 10/10/22 by the Regional Director of Care Services on the need to monitor, track, educate, and implement precautions to prevent the spread of an identified communicable condition among residents and staff. Current staff was retrained on 10/4/2022 by the CSM on the need to monitor, track, educate, and implement precautions to prevent the spread of an identified communicable condition among residents and staff, including exclusion from work while infected with a communicable disease or infection 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:** Effective 10/26/22, the CSM or designee will complete an audit of the infection control log to monitor track, educate, and implement precautions to prevent the spread of an identified communicable condition among residents and staff. The audit will occur weekly	

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	An interview with Staff 1, on 9/26/22, indicated the employee has had a rash for over a month, had been to a couple different doctors, and received medicine, but it had not gone away. A dermatologist was then seen and indicated it was scabies and prescribed medication, which had still not completely cleared up the rash. Staff 1 indicated the facility was aware of the rash and at no time indicated to stay home from work. A list of 10 residents was then presented by Staff 1 who had recently been assessed as having a rash or bumps and it was indicated the physician had not yet been notified. An interview with Staff 2, on 9/26/22, indicated facility training had been completed last month and the facility had not informed them any residents had a rash. One of the assigned duties was resident laundry, for which gloves had been worn & clothing washed on hot. The first time Staff 2 was aware of any issues with residents or staff having a rash was a couple weeks ago when staff were discussing it. "They were keeping it all hush, hush and should have made staff aware of any outbreak." An interview with Staff 3, on 9/26/22, indicated 2 residents had developed a rash last month. The current CSM and former CSM at the time had bagged the items from those rooms because they thought the residents might have had scabies and Staff 3 had assisted. They wore gloves and gowns, and everything was taken to a local laundromat. Staff 3 was told it was not bed bugs, but there was no definitive cause ever shared and those residents were started on a cream. Then, a couple weeks ago, staff had been talking about having rashes and several indicated they were told by a dermatologist it was scabies. Staff 3 was observed scratching both arms during the		for 4 weeks, biweekly for 4 weeks, then monthly for 4 weeks. The audits will be overseen by the Executive Director for accuracy and correctness. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of 100% compliance. Monitoring will be on-going.	

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	interview and indicated there was a rash that would come and go. The facility was aware of the rash and had never indicated not to come to work. An interview with the Business Office Manager (BOM), on 9/26/22 at 11:25 a.m., indicated a housekeeping and a maintenance staff member had been diagnosed with scabies today and she was unsure if she should not have them work. An interview with the Maintenance Director, on 9/26/22 at 2:36 p.m., indicated a member of the housekeeping staff had just been sent home that morning with a rash believed to be scabies. There were 2 residents about a month ago who had a rash, so he had sprayed those rooms with a professional [company name] spray that was "supposed to kill almost anything." He then sprayed the other rooms, common areas and high touch areas like handrails with a peroxide multi-surface cleaner and also an alcohol/water spray. The rooms were sprayed every day for about a week and a half. He was unaware the staff & residents were still having issues. A facility policy titled, "Preventing Transmission of Infection," was presented as current by the CSM on 9/26/22 at 2:00 p.m. The policy indicated, " .... employees with transmissible infectious diseases or infected skin lesions shall not have direct contact with residents, prepare food, and/or serve food ...." A follow up interview with the CSM, on 9/26/22 at 3:40 p.m., indicated staff who presented with a rash should not come to work according to facility policy. This state residential finding relates to Complaint IN00390943.			

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