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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRAIL CREEK PLACE	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. 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 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency 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.	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	02/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy Miller	Executive Director	02/12/2025

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 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 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 from the routine operation of the community. 2. Unusual occurrences are those that directly threaten the		potential to be affected by the same deficient practice and 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.	

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	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..."		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.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency 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:	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	02/14/2025

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	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		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	

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	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.		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.	