| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155103 | A. Building<br>B. Wing | 06/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Trailpoint Village | 1950 Ridgedale Rd<br>South Bend, IN 46614 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>Based on observation, interview and record review, the facility failed to prevent the misappropriation of narcotics for 1 of 4 residents receiving narcotics reviewed. (Resident C)<br><br>Finding includes:<br><br>On 6/12/25 at 12:16 P.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: respiratory failure with hypoxia-tracheostomy, diabetic neuropathy, dysphagia (difficulty swallowing), diabetes and chronic kidney disease.<br><br>A current Care plan for pain, initiated on 4/28/25, indicated the resident was at risk for pain related to impaired mobility and diabetic neuropathy. The interventions included, but were not limited to: notify physician if pain is unrelieved and/or worsening, assist with positioning to comfort, administer medications as ordered and document effectiveness of pain medications.<br><br>A Nursing Progress Note, dated 5/15/25 at 7:56 A.M., indicated the previous shift had reported the resident's narcotics had been held since 2:00 P.M. on 5/14/25. In addition, they had reported the resident had slept most of the previous shift. After the nursing staff had relayed their converns to Director of Nursing, it was decided to send the resident to a local hospital for an evaluation and treatment.<br><br>A facility census event for Resident C indicated on 5/15/25 at 8:25 A.M., the resident had a Hospital Leave/ER Visit. On 6/2/25 at 5:40 P.M., the census indicated the resident had a Return from Hospital Leave.<br><br>The Medication Administration Record for May 2025 for Resident C, indicated the resident had an order for Oxycodone (narcotic pain medication) 10 milligrams every 8 hours (6:00 A.M., 2:00 P.M. 10:00 P.M.). The last dose of Ocycodone had been administered to Resident C on 5/14//25 at 2:00 P.M. with no doses given at 10:00 P.M. The MAR indicated there had been no narcotic medication administered to Resident C through the month of May.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A facility self-reported incident, dated 5/23/25 at 12:01 P.M., indicated .Facility noted 5 missing Oxycodone pills were missing during an audit. The count was correct prior to [name of LPN 7] shift LPN 7 was suspended pending the investigation. Resident C had been in the hospital during the time the medication was noted to be missing. A follow up to incident report, on 5/28/25 indicated .a discrepancy was identified during a narcotic audit, prompting an internal investigation. [name of LPN 7] was identified as having access to the medication in question. When approached, the staff member was asked to complete a drug screen and provide a written statement. She refused both requests and subsequently left the building. Police report was filed. The staffing agency responsible for the employee was also notified of the incident and investigation findings .Consumer complaint was filed on staff member<br><br>A typed statement by RN 8, dated 5/23/25, indicated RN 8 had been doing her assigned narcotic audit and requested the cart keys from LPN 7. RN 8 noted Resident C's narcotic cards had been repositioned towards the back of the other cards. RN 8 asked LPN 7 why were Resident C's cards out of order to which LPN 7 replied she had placed them there because the drawer was stuffed. RN 8 noticed there were 5 Oxycodone missing. RN 8 questioned LPN 7 where the Ocycodone had gone and who did she get report from and the LPN did not respond. RN 8 took Resident C's narcotic medication cards to the Director of Nursing to report the drug diversion.<br><br>A typed statement by the Director of Nursing (DON), dated 5/23/25 at 11:05 A.M., indicated RN 8 had informed the DON of the missing Oxycodone for Resident C during her cart/narcotic audit. The DON had verified there were 5 Oxycodone missing from Resident C's narcotic card. The DON was instructed by Human Resources to have a drug test completed on LPN 7, as directed by the facility's policy. LPN 7 refused to be drug tested, threw the cart keys towards the nurses station, grabbed her things and headed towards the exit. DON and 2 other nurse managers walked along with LPN 7 until they reached the front lobby. At that time, LPN 7 pushed past the nurse managers and exited the building.<br><br>A hand written statement by RN 2, on 5/23/25, indicated when she had counted the narcotics with LPN 7 (prior to the start of LPN 7's shift) the narcotic count had been correct.<br><br>A picture of the narcotic cards and the Controlled Substance Record were observed on 6/12/25 for Resident C, which revealed the last dose of Oxycodone was removed from the card, on 5/14/25 at 2:00 P.M., with a count at 75 tablets, however the Ocycodone card only had 70 Oxycodone left on the card.<br><br>During an interview, on 6/12/25 at 11:29 A.M., the DON indicated Resident C had been discharged a couple of days prior to the discovery of his narcotics missing. The DON indicated LPN 7 had been an agency nurse and was unaware there was an ongoing audit of narcotics being conducted throughout facility. The DON indicated LPN 7 had been suspended but there had been no contact with LPN 7 since her departure.<br><br>On 6/12/25 at 9:54 A.M., the Administrator provided a policy titled, Abuse Prohibition, Reporting, and Investigation, dated June/2023 and indicated the policy was the one currently used by the facility. The policy indicated .It is the policy of [name of facility] to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation .Misappropriation of Resident Funds or Property - Deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's property or money without the resident's consent<br><br>3.1-28(a) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on record review and interview, the facility failed to ensure a CNA (Certified Nurse Assistant) followed the resident's comprehensive care plan and the facility's Mechanical Lift/Hoyer Lift Safety procedure during a transfer from the resident's wheelchair to bed. This resulted in the resident falling to the floor and sustaining multiple fractures and requiring hospitalization. (Resident B)<br><br>The Immediate Jeopardy began on 5/29/25 at 4:28 P.M., when a CNA failed to follow a resident's comprehensive care plan and transferred a resident, via a Hoyer lift, from a wheelchair to the bed, without assistance. This deficient practice resulted in a fall, from a Hoyer sling, to the ground, in which the resident sustained multiple fractures and requiring hospitalization. The Administrator, the Director of Nursing and Regional [NAME] President were notified of the Immediate Jeopardy on 6/13/25 at 11:36 A.M.<br><br>The deficient practice was corrected on 6/6/25, prior to the start of the survey, and was therefore past noncompliance.<br><br>Finding includes:<br><br>On 6/12/25 at 1:28 P.M., a review of the clinical record for Resident B was conducted. The resident's diagnoses included, but were not limited to: chronic respiratory failure with dependence on ventilator, artificial opening of gastrointestinal tract-gastrojejunostomy tub (G-tube), cerebral palsy, paraplegia, and an anxiety disorder.<br><br>An Activities of Daily Living (ADL) care plan, dated 12/26/23 and revised on 3/27/25, indicated the resident required assistance with ADLs which included bed mobility and transfers related to a diagnosis of cerebral palsy. Interventions included but were not limited to: assist with transfers, then on 3/12/24, an intervention of transfers with 2 person assist with a Hoyer lift was added.<br><br>A Fall care plan, dated 12/26/23 and revised on 3/27/25, indicated the resident was at risk for falls due to impaired mobility. There were no specific interventions related to the resident's needs for transfers on the plan.<br><br>A Minimum Date Set (MDS) annual assessment, dated 3/24/25, indicated Resident B was dependent on staff for transfer assistance and had had no falls since his admission.<br><br>A Fall Risk assessment, dated 3/20/25, indicated the resident was had a moderate risk for falls.<br><br>A Fall Event form, dated 5/29/25 at 5:10 P.M., indicated CNA 3 reported the resident had fallen out of the side of the Hoyer pad during a transfer. CNA 3 reported she had used her body to guide the resident's fall to the floor. The Respiratory Manager had assisted CNA 3, immediately after the fall, with getting the Hoyer pad back underneath the resident and then CNA 3 had transferred Resident B back into his bed. The form indicated the Immediate intervention was that CNA 3 was instructed on Hoyer (mechanical lift) use with 2 persons.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A Nursing Progress Note, dated 5/29/25 at 5:19 P.M., indicated CNA 3 had reported the resident had fallen while she was transferring him from the wheelchair to his bed. The note indicated the following: .CNA states that she used her body to guide resident fall to floor, but left forehead hit the floor, RT [Respiratory] manager present with CNA and assisted getting resident on hoyer pad and into bed. Dime sized Hematoma present above left eyebrow, ice in place<br><br>A Nursing Progress Note, dated 5/29/25 at 8:55 P.M., indicated Resident B had fallen and had hit his head earlier in the afternoon. Resident B had later demonstrated neurological changes and appeared cold and clammy., The resident's vital signs were documented as the following: Blood pressure 80/53, Pulse 123 and respirations were 42. At 8:23 P.M., 911 was called to transfer the resident to the hospital for an evaluation for a possible intracranial pressure/bleeding. The paramedics had arrived at 8:38 P.M. and the resident was taken to a local hospital.<br><br>A typed form, titled Fall Incident Timeline: Hoyer Lift Transfer with injury indicated the following:<br><br>-Date of incident: 5/29/25<br><br>-At 2:00 P.M., RN 2 had spoken with CNA 3 to ensure her if she needed assistance with transferring Resident B, with a Hoyer, to let her know and she would help CNA 3. CNA 4 also had told CNA 3 he would assist her when she needed assistance.<br><br>-At 2:35 P.M., CNA 3 had attempted to transfer Resident from his wheelchair to his bed using the facility approved Hoyer lift. During the transfer, the resident had slid out of the sling and fell to the ground.<br><br>-At 2:45 PM The nurse was promptly notified. An initial assessment was conducted, revealing only a small hematoma above the Resident's left eyebrow. Vital signs were stable<br><br>-At 8:30 P.M., the resident demonstrated a change of condition, which prompted an immediate re-assessment. The decision was made to have the resident transported to a local emergency department for an evaluation.<br><br>-On 5/30/25 at 10:30 A.M., the hospital records confirmed the resident had sustained multiple fractures from the fall and the incident was reported to the Indiana State Health Department.<br><br>-The typed form indicated additional facts: CNA 3 had been trained on the proper Hoyer techniques, on 11/6/24 and signed a Mechanical Lift/Hoyer Lift Safety attestation on 11/6/24. A copy of the attestation indicated .1. I understand that all mechanical lifts, including hoyer lifts require the use of 2 people to operate safely .I understand that if I operate a mechanical lift by myself, I am subject to disciplinary action up to and including termination In addition, a skills competency form regarding Hoyer transfer techniques had been completed by CNA 3 in July 2024.<br><br>The Conclusion indicated the following: .Investigation shows the root cause of the fall was that the care plan was not followed during the transfer. The employee received the proper training prior to the incident and staff were available for assistance at the time of the incident but were not notified to assist<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A typed statement/interview, dated 5/29/25 (no time), indicated RN 2 had told CNA 3 she would assist her with any transfers on 5/29/2025 prior to the resident's fall.<br><br>A typed statement/interview from CNA 3, undated (no time), indicated she had transferred Resident B and he slipped out of the Hoyer sling. The Administrator indicated she had interviewed CNA 3 on 5/30/25 and the only explanation provided had been the resident's buttock was possibly not positioned correctly in the sling prior to the transfer.<br><br>A typed statement by the Respiratory Manager, undated (no time), indicated CNA 3 had came to Respiratory Manager searching for RN 2. CNA 3 indicated she needed assistance with Resident B and she had followed CNA 3 into Resident B's room. The Hoyer lift was still elevated with the Hoyer sling/pad attached to the Hoyer lift machine. The resident was located on the floor laying on his left side, with his body between the legs of the Hoyer. CNA 3 told the Respiratory Manager the resident had fell off the Hoyer. The Respiratory Manager indicated she had then assisted CNA 3 to position the sling underneath the resident. She indicated CNA 3 then lifted Resident B up from the floor onto his bed with the Hoyer lift.<br><br>A Hospital History and Physical, dated 5/29/25 at 11:55 P.M., indicated the resident presented to the emergency room (ER) with hypoxia (low levels of oxygen in the body tissue) after a fall earlier in the afternoon. In the ER the resident had profuse vomiting and there were concerns regarding a potential G-tube displacement. A CT (Computerized Tomography) of the abdomen and pelvis was conducted which revealed the G-tube was present with tip of the catheter located within the stomach, however, there were acute bilateral femoral (hip) fractures, a right superior pubic ramus (lower pelvis) fracture, a left iliac wing (upper pelvis) fracture and a left sacral (bones at the base of the spine ) fracture.<br><br>A facility self-reported incident, dated 5/30/25 at 9:01 A.M., indicated the resident had experienced a fall while being transferred, using a Hoyer lift and had sustained multiple fractures. .Root cause of fall was that the care plan was not followed during transfer<br><br>An Employee Communication Form for CNA 3, dated 6/2/25 indicated .Employee demonstrated gross disregard of resident safety by failing to follow established procedures for transferring residents. Specifically, the staff member attempted to use a Hoyer lift without the required second staff member, resulting in a fall and injury to the resident. This action demonstrates as serious violation of safety protocols and placed the resident at significant risk, warranting immediate termination<br><br>On 6/13/25 at 9:30 A.M., the Administrator provided a skills competency form titled, Mechanical Lift, dated 8/2023 which indicated .Two (2) staff is required at all times when using a mechanical lift<br><br>During an interview, on 6/13/25 at 2:01 P.M., the Administrator indicated the resident had been in the hospital since the day of his fall and would possibly return to the facility on 6/13/2025. She indicated the incident report had been filed the next day as the facility had not received a report from the hospital regarding the resident's injuries until 5/30/25. She indicated CNA 3 had been suspended on 5/30/25, until further investigation.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview, on 6/16/25 at 10:57 A.M., the Respiratory Manager indicated CNA 3 had asked for help and when she entered Resident B's room he was located on the floor and the Hoyer lift was over him. She indicated she had only assisted the CNA with positioning the resident onto the Hoyer sling. Then CNA 3 lifted the resident, via the Hoyer lift and lowered the resident onto his bed.<br><br>During an interview, on 6/16/25 at 11:00 A.M., RN 2 indicated CNA 3 came to her and told her Resident B had fallen. When she entered the room, the resident was tucked in bed and the Hoyer lift was in the hallway. She indicated CNA 3 should have not moved the resident until she had assessed him for injuries.<br><br>On 6/13/25 at 9:30 A.M., the Administrator provided a policy titled, Fall Management Policy, dated 8/2022 and indicated the policy was the one currently used by the facility. The policy indicated .It is the policy of [name of the facility] to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls .Facilities must implement comprehensive, resident-centered fall prevention care plans for each resident at risk for falls<br><br>The Past Noncompliance Immediate Jeopardy began on 5/30/2025. The Immediate Jeopardy was removed and corrected by 6/6/25 after the facility implemented a systemic plan of correction that included the following actions: all nursing staff were re-educated on Hoyer use and the need for 2 persons to perform a transfer via a Hoyer lift, return demonstration/skills check off on Hoyer transfers were conducted with all nursing staff, resident care plans were reviewed to ensure their transfer care plans were updated with the correct number of staff needed for their transfer needs, staff were educated regarding the notification of the a Charge Nurse following a fall for an assessment of possible injuries, a daily observation/audit of resident transfers was initiated on 6/2/25 and was ongoing and the QAPI (Quality Assurance and Performance Improvement) to review audit tool ongoing.<br><br>This citation relates to Complaint IN00460600.<br><br>3.1-45(a)(2) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on interview and record review the facility failed to ensure staff members acted competently and followed facility protocol regarding notification and assessment of a licensed nurse after a resident experienced a fall prior to moving the resident for 1 of 3 residents reviewed for falls. (Resident B)<br><br>Finding includes:<br><br>On 6/12/25 at 1:28 P.M., a review of the clinical record for Resident B was conducted. The resident's diagnoses included, but were not limited to: chronic respiratory failure with dependence on ventilator, artificial opening of gastrointestinal tract-gastrojejunostomy tub (G-tube), cerebral palsy, paraplegia, and an anxiety disorder.<br><br>A Fall Event form, dated 5/29/25 at 5:10 P.M., indicated CNA 3 reported the resident had fallen out of the side of the Hoyer pad during a transfer. CNA 3 reported she had used her body to guide the resident's fall to the floor. The Respiratory Manager had assisted CNA 3, immediately after the fall, with positioning the Hoyer pad back underneath the resident and then assisted to transfer Resident B back into his bed. The form indicated the Immediate intervention was that CNA 3 was instructed on Hoyer use with 2 persons.<br><br>A Nursing Progress Note, dated 5/29/25 at 5:19 P.M., indicated CNA 3 had reported the resident fell while she was transferring him from the wheelchair to his bed. The note indicated the following: .CNA states that she used her body to guide resident fall to floor, but left forehead hit the floor, RT [Respiratory] manager present with CNA and assisted getting resident on hoyer pad and into bed. Dime sized Hematoma present above left eyebrow, ice in place<br><br>A typed statement by the Respiratory Manager, undated (no time), indicated CNA 3 had came to Respiratory Manager searching for RN 2. CNA indicated she needed assistance with Resident B and she had followed CNA 3 into Resident B's room. The Hoyer lift was still elevated with the Hoyer sling/pad attached to the Hoyer lift machine. The resident was located on the floor laying on his left side, with his body between the legs of the Hoyer. CNA 3 told the Respiratory Manager the resident had fell off the Hoyer. The Respiratory Manager indicated she had then assisted CNA 3 to position the sling underneath the resident. She indicated CNA 3 then lifted Resident B up from the floor onto his bed with the Hoyer lift.<br><br>An Employee Communication Form, signed on 6/2/25, by the Respiratory Manager and the Administrator, indicated the following: .Staff member was educated on residents who have experienced a fall must be assessed by a nurse before any attempt is made to move or assist them. This ensures that potential injuries are properly evaluated and that the resident's safety is not compromised. Assisting a resident up before nursing assessment can lead to further harm and violates facility protocol. Please ensure that all falls are immediately reported to the nurse and that no movement occurs until the resident has been assessed<br><br>During an interview, on 6/13/25 at 2:01 P.M. the Administrator indicated CNA 3 and the Respiratory Manager should have notified the nurse of the resident's fall prior to moving him. She indicated the Respiratory Manager was new and had been instructed on the facility's protocol since the incident.<br><br>(continued on next page) |

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