

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2025
NAME OF PROVIDER OR SUPPLIER  Trailpoint Village		STREET ADDRESS, CITY, STATE, ZIP CODE  1950 Ridgedale Rd 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for abuse was free from abuse, when a previous staff member verbally abused the resident while exiting the facility following her resignation, (Resident C). Finding includes: On 8/14/25 at 12:00 P.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to osteomyelitis, type 2 diabetes with diabetic polyneuropathy, and spinal stenosis. Resident C's Care Plans included but were not limited to, Resident displays verbal aggression towards others when feeling frustrated with them, initiated on 7/30/25. Review of a facility Incident Number 668, reported to the State Agency on 8/8/25, indicated on 8/8/25 at 4:01 P.M., Resident C reported that the previous Unit Manager, Licensed Practical Nurse (LPN) 5, went up to him on her way out of the facility and spoke rudely to him after telling him she had quit. The staff member had resigned and was terminated from the system when an investigation was initiated. All appropriate parties were notified. Staff and residents were interviewed regarding the potential abuse with negative findings. Upon investigation, the facility follow-up, dated 8/13/25, indicated other staff and resident were interviewed and indicated they had heard an interaction between LPN 5 and Resident C, but were not able to make out what was said. The resident had suffered no psychosocial distress. During an interview on 8/14/25 at 1:20 P. M., Resident C indicated LPN 5 was not a good nurse and had failed to order pain medications in a timely manner on two occasions and had also failed to arrange for transportation to an appointment for him. The resident indicated he was able to use Tylenol for pain and staff had transported him to his appointment. Resident C indicated that LPN 5 had to apologize to him, per the administration's direction, which upset her and so was unhappy with him. Resident C indicated LPN 5 was in the facility on 8/8/25 to hand in her resignation and as she was leaving the building, went to the 400 Hall Nurse's Station where he was seated in his wheelchair, approached the resident and told him he was a piece of shit. During an interview on 8/15/25 at 10:00 A.M., the Administrator indicated on 8/8/25, LPN 5 came to the facility to resign her position. As she was leaving the facility, LPN 5 had gone to Resident C, who was near the Nurse's Station, and had spoken rudely to him. The Administrator indicated she was made aware of the incident after Resident C reported it to the staff. The Administrator indicated she went to the resident immediately and initiated an investigation and reported the incident to the State Agency. The Administrator indicated it was inappropriate for LPN 5 to speak to the resident in a rude manor. On 8/15/25 at 12:30 P.M., the Administrator provided the policy, Abuse Prohibition, Reporting, and Investigation, dated 6/23, and indicated it was the current facility policy. The policy indicated, .It is the policy of [facility] to provide each resident with an environment that is free from abuse.This includes but is not limited to verbal abuse.[facility] will not permit resident to be subjected to abuse by anyone, including employees.friends, or other individuals.Verbal Abuse- The use of oral language that willfully includes disparaging and derogatory terms to residents. This citation relates to Intake 25884363. 1-27(a)(b)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155103
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