STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155103	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trailpoint Village	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44111 Based on observation, interview and record review, the facility failed to ensure medications were labels and stored according to professional priniciples on 3 of 4 medication carts observed. (Memory Care, 100 Hall & 400 Hall) Findings include: 1. On 2/27/2025 at 9:30 A.M., a medication storage observation was completed with RN 2 on the Memory Care cart, the following was observed: An opened, undated and unlabeled bottle of calcium magnesium with zinc capsules. In addition, there was a bottle of One a Day Men 50 + vitamin supplement with only a resident's first name written on the lid of the bottle. During an interview on 2/27/2025 at 9:40 A.M., RN 2 indicated a family member had brought them in and the bottles should have had labesl and an opened date on them. 2. On 2/27/2025 at 10:47 A.M., a medication storage observation was completed with RN 3 on the 100 Hall cart and the following was observed: Three bottles of prescirption eye drops were stored the same drawer as oral medications. One of three bottles of eye drops was not labeled with complete instructions regarding which eyes were to have drops administered. During an interview on 2/27/2025 at 11:00 A.M., RN 3 indicated she was not aware eye drops could not be stored next to oral medications, but she had been instructed by the DON that the eye drop bottles needed to be stored upright in the cart. She indicated the bottle of eye drops with incomplete instructions should have indicated the drops were to be instilled in the resident's right eye. 3. On 2/27/2025 at 1112 A.M., a medication observation was completed with the Unit Manager on the 400 Hall cart and the following was observed: An opened and undated bottle of nasal spray. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An opened and undated bottle of eye drops. During an interview on 2/27/2025 at 11:33 A.M., the Unit Manager indicated the bottles should have had an opened date. On 2/27/2025 at 11:41 A.M., the Regional Nurse Consultant provided a policy titled, Medication Storage and Expiration Policy, dated 11/2024, and indicated the policy was the one currently used by the facility. The policy indicated . 2. Internal (oral) medications should be stored separately from external (not taken orally) mediations 9. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler). On 2/28/2025 at 2:45 P.M., the Regional Nurse Consultant provided a policy titled, Over-The -Counter (OTC) Medications, dated 2022, and indicated the policy was the one currently used by the facility. The policy indicated . Order: Ensure prescriber order is in place for all OTC medications and Label patient-specific OTC's per facility policy (e.g., first initial, last name, room #) . On 2/28/2025 at 2:52 P.M., the Administrator provided a policy titled, Medication Brought Into the Facility, dated 12/1/2017, and indicated the policy was the one currently used by the facility. The policy indicated Facility staff should not administer medications, including over-the-counter mediations, naturally occurring substances, and physician/perscriber medication samples, brought to the facility by a resident, a resident's responsible party, or a resident's physician/prescriber without a physician/perscriber order . 3.1-25(l)(1) 3.1-25(l)(2) 3.1-25(l)(3) 3.1-25(l)(4) 3.1-25(l)(5)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 51598 Based on record review and interview, the facility failed to ensure advanced directives were coordinated with hospice for 1 of 2 residents reviewed for hospice services. (Resident 28) Finding includes A record review for Resident 28 was completed on 2/26/2025 at 9:45 A.M. Diagnosis included, but were not limited to occlusion and stenosis of right posterior cerebral artery, metabolic encephalopathy, dementia, schizoaffective, borderline personality, bipolar, and aortic stenosis. A Physicians Order dated 11/25/2024, indicated the resident was a full code. Resident 28's care plan, initiated on 11/26/2024, indicated the resident and/or the resident's legal representative preferred a full code status. A Physician's Order dated 2/11/2025 indicated an order for hospice for Resident 28 for end of life care. Review of the hospice initial plan of care, dated 2/10/2025, indicated an advanced directives of Do Not Resuscitate (DNR) code status. A Physician Orders for Scope of Treatment (POST) form, signed on 2/10/2025 indicated Resident 28's code status was now a DNR. The facility was not notified by the hospice provider of the change until 2/28/2025. During an interview with the Administrator on 2/28/2025 at 11:40 A.M., she indicated when someone transitioned to Hospice care, the hospice provider was responsible to write orders for any changes being made. She indicated the hospice provided had not communicated to the facility any changes for code status for Resident 28. The administrator indicated she had called the Hospice administrator on 2/28/2025 and verified there was a POST form for Resident 28 indicating a change in the advance directives/code status to a DNR. On 2/28/2025 at 1:30 P.M., the Administrator provided a policy titled, Advanced Directives and indicated the policy was the one currently used by the facility. The policy indicated The DNR status will be reviewed with resident/representative during the quarterly care plan conference and/or during significant changes in condition There was no policy provided regarding communication between the hospice providers and the faclity to ensure all new orders were updated timely. 3.1-37(a)