

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155805	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Addison Pointe Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 780 Dickinson Road Chesterton, IN 46304	

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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>48383</p> <p>Based on observation, record review, and interview, the facility failed to file and resolve a resident grievance for a missing wheelchair for 1 of 1 resident reviewed for grievances. (Resident M)</p> <p>Finding includes:</p> <p>On 7/30/24 at 1:20 p.m., Resident M was observed awake, sitting up in bed and talking with his son. Resident M indicated he was unhappy with how the facility handled his missing wheelchair.</p> <p>During an interview at that time, Resident M indicated he had been missing a personal wheelchair since before Father's Day. The facility was aware his wheelchair was missing and he was told they would get him fitted for another wheelchair. The resident's son talked with the the therapy director a couple weeks ago, and it was communicated that the resident would be measured for a new wheelchair the following day. They were unsure if the facility had a grievance on file for their concern.</p> <p>Resident M's record was reviewed on 7/30/24 at 3:59 p.m. Diagnoses included, but were not limited to, heart failure, chronic pain, arthritis, insomnia (difficulty sleeping), gout (excess of uric acid in joints), and hypertension (high blood pressure).</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the resident was moderately intact for daily decision making. The resident had impairment on both sides of his lower extremities and used a wheelchair. The resident was dependant with toileting, shower/bathing, and lower body dressing. Personal hygiene required partial/moderate assistance.</p> <p>A Therapy Note, signed by the Rehabilitation Director and dated 7/24/24, indicated due to the resident's weight gain, he would likely require a larger chair. The resident and son agreed to Resident M getting fitted for a new chair within the next day or so.</p> <p>During an interview on 7/30/24 at 3:01 p.m., the Social Service Assistant indicated Resident M's wheelchair was found shortly after it went missing. The wheelchair was returned to the resident and they refused it, indicating it was the wrong wheelchair. When they attempted to measure the resident, he refused to get out of bed. There was a wheelchair in the resident's room and the resident had it stored in the bathroom. A grievance for the missing wheelchair was filed today on 7/30/24 and there was not one previously filed. There was no additional information provided.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155805	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Addison Pointe Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 780 Dickinson Road Chesterton, IN 46304	

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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/31/24 at 9:38 a.m., the Administrator indicated she understood the grievance concern and had no additional information to provide.</p> <p>3.1-7(a)(2)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155805	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Addison Pointe Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 780 Dickinson Road Chesterton, IN 46304	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48055</p> <p>Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members when providing care to a resident who was in Enhanced Barrier Precautions (EBP) for 1 of 3 residents reviewed for infection control isolation practices. (RN 1, CNA 1, and Resident E).</p> <p>Finding includes:</p> <p>During an observation on 7/30/24 at 11:45 a.m., Resident E was observed lying in bed in the room. There was a sign on the door that indicated the resident was in EBP and PPE of a gown and gloves was to be worn during high contact activities. CNA 1 brought a Hoyer (mechanical) lift to Resident E's room and attempted to transfer Resident E. CNA 1 then asked RN 1 to assist her in the transfer of Resident E. RN 1 sanitized her hands and entered Resident E's room, where she assisted with the Hoyer lift transfer. Both CNA 1 and RN 1 were not wearing the proper PPE which included gowns and gloves.</p> <p>During an interview with RN 1 on 7/30/24 at 11:50 a.m., she indicated the staff does not apply PPE unless they were actually touching the resident's wound.</p> <p>Resident E's record was reviewed on 7/30/24 at 11:30 a.m. The diagnoses included, but were not limited to, difficulty walking, dementia, and displaced mid cervical fracture of the left femur.</p> <p>A Physician's Order, dated 4/22/24, ordered enhanced barrier precautions for a chronic sacral wound.</p> <p>A Care Plan, dated 5/22/24, indicated the resident required enhanced barrier precautions related to a chronic sacral wound. Interventions included to follow enhanced barrier precautions with the resident's care as needed, and to provide the resident's treatments as ordered.</p> <p>During an interview with the Wound Nurse on 7/30/24 at 2:32 p.m., she indicated the resident had a coccyx wound that was infected with Methicillin Resistant Staphylococcus Aureus (MRSA) in April of 2024, and the staff should apply the appropriate PPE when providing care and transferring the resident.</p> <p>The facility policy titled, Infection Prevention and Control Program (IPCP), Enhanced Barrier Precautions, provided by the Director of Nursing as current on 7/31/24 at 10:24 a.m., indicated . staff can use gloves and gowns in order to prevent contamination of hands and clothing while performing high-contact resident care that poses the highest risk for MDRO (Multi Drug Resistant Organisms) transmission. These high contact activities include dressing, bathing, or providing hygiene, transferring, changing briefs, or assisting with toileting, changing linens, or providing any type of device or wound care</p> <p>This citation relates to Complaint IN00435593.</p> <p>3.1-18(b)</p>		