STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155805	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Pointe Health & Rehabilitation Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43293 Based on observation, record review, and interview, the facility failed to implement a resident's care plan related to positioning for 1 of 3 residents reviewed for limited range of motion (ROM). (Resident 33) Finding includes: During an observation on 3/17/25 at 10:00 a.m., Resident 33 was observed resting in bed. He had limited movement of his left arm and his left hand appeared contracted (unable to open). At that time, the resident indicated he could only open his left hand if he used his right hand to open it since he had had a stroke. There were no rails or bars present on the bed. During the following observations on 3/18/25 at 9:54 a.m., 3/19/25 at 10:37 a.m. and 3/20/25 at 11:00 a.m., the resident was lying in bed and there were no rails or bars present on his bed. The resident's record was reviewed on 3/20/25 at 10:06 a.m. Diagnoses included, but were not limited to, disorders of the brain, vascular dementia, and chronic heart failure. The 2/24/25 Quarterly Minimum Data Set (MDS) assessment, indicated the resident had severe cognitive impairment and was dependent on staff for assistance for ADLs (activities of daily living) and transfers. A Physician's Order, dated 1/18/25, indicated the resident was to have a left side enabler bar (a bar that attaches to the bed for the resident to use to assist with turning and repositioning). A Care Plan, revised on 1/20/25, indicated the resident needed assistance with ADLs related to activity intolerance and impaired cognition. Interventions included the use of a left side enabler bar for turning and repositioning. During an interview on 3/21/25 at 9:04 a.m., the Unit Manager for the 100 and 200 halls indicated she thought the resident used to have an enabler bar, but she did not know what happened to it. She indicated she would have to look into getting him one. 3.1-35(a)

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 03/21/2025
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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 43293 Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents, related to turning and repositioning for 1 of 2 residents reviewed for ADLs. (Resident 33) Finding includes: During an observation on 3/17/25 at 10:00 a.m., Resident 33 was observed resting in bed, lying on his back. He had limited movement of his left arm and his left hand appeared contracted (unable to open). During the following observations on 3/18/25 at 9:54 a.m. and 2:14 p.m., 3/19/25 at 10:37 a.m., and 3/20/25 at 9:35 a.m. and 11:00 a.m., the resident was lying in bed on his back. The resident's record was reviewed on 3/20/25 at 10:06 a.m. Diagnoses included, but were not limited to, disorders of the brain, vascular dementia, and chronic heart failure. The 2/24/25 Quarterly Minimum Data Set (MDS) assessment, indicated the resident had severe cognitive impairment, and was dependent in ADLs (activities of daily living) and transfers. A review of a Care Plan, revised on 9/4/24, indicated the resident had hemiplegia (paralysis of one side of the body) to his left side and required staff assistance with ADLs. Interventions included to assist/encourage him to change his position frequently. The Tasks section of the record indicated the resident should have been turned and repositioned every shift. There was no documentation of turning/repositioning or resident refusals to be turned for the following shifts: 2/24/25 night shift, 2/26/25 night shift, 2/28/25 night shift, 3/2/25 night shift, 3/4/25 night shift, 3/7/25 night shift, 3/8/25 night shift, 3/9/25 night shift, 3/13/25 day and evening shifts, 3/14/25 night shift, and 3/16/25 night shift. During an interview on 3/21/25 at 9:04 a.m., the Unit Manager for the 100 and 200 halls indicated the resident did not get out of bed, and the staff should have documented either repositioning or resident refusal every shift. 3.1-38(a)(3)

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 03/21/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 10326 Based on observation, record review, and interview, the facility failed to ensure areas of discoloration were assessed and monitored for 2 of 2 residents reviewed for non-pressure skin conditions .(Residents 62 and 44) Findings include: 1. On 3/17/25 at 9:47 a.m., Resident 62 was observed with two small areas of reddish/purple discoloration to his right elbow. On 3/18/25 at 2:03 p.m. and 3/19/25 at 10:01 a.m., the discoloration remained to the resident's elbow. The record for Resident 62 was reviewed on 3/18/25 at 2:55 p.m. Diagnoses included, but were not limited to, Parkinson's disease, anemia, and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 3/5/25, indicated the resident was moderately impaired for daily decision making and had no skin issues. The Weekly Skin Observation Assessment, dated 3/17/25 at 3:06 a.m., indicated the resident had no bruising. The March 2025 Physician's Order Summary (POS), indicated there were no orders to monitor the areas of discoloration to the resident's right elbow. During an interview on 3/19/25 at 1:50 p.m., the Wound Nurse indicated she had noticed the areas of purpura (a rash of purple spots) on the resident's arms on the morning of 3/19/25. She indicated there was more of the rash noted on the left arm than on the right and she had filled out a skin form. The Wound Nurse had been informed of the areas of discoloration near the right elbow which had been observed on 3/17/25. The Non-Pressure Ulcer Skin Condition Progress Report, dated 3/19/25 at 10: 56 a.m., indicated scattered purpura was observed to the upper extremities, more prevalent on the left arm. Continue to monitor. 43293 2. During a random observation on 3/17/25 at 10:31 a.m., large dark purple bruises were observed on the back of Resident 44's left and right hands. At that time, the resident's family member indicated the bruises had been there since the resident had left the hospital on 2/25/25. The bruises to both hands remained present during the following observations: 3/18/25 at 2:04 p.m., 3/19/25 at 3:10 p.m. and 3/20/25 at 9:28 a.m. (continued on next page)

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 03/21/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's record was reviewed on 3/18/25 at 2:17 p.m. Diagnoses included, but were not limited to, post-hip replacement, dementia, and muscle weakness. The 2/27/25 Admission Minimum Data Set (MDS) assessment, indicated the resident had severe cognitive impairment and was dependent in Activities of Daily Living (ADLs) and transfers. A Care Plan, revised on 2/27/25, indicated the resident was at risk for abnormal bruising and bleeding related to the use of blood thinners. Interventions included observing for bruising and bleeding. The treatment record included observing for side effects of blood thinners every shift. Each shift from 2/26/25 through 3/20/25 indicated no side effects were noted. The nurses' skin assessments from 2/25/25 through 3/20/25 lacked documentation of the bruises to the hands. During an interview on 3/21/25 at 9:19 a.m., the Unit Manager indicated the bruises should have been assessed and documented in the record. She indicated she could not find any documentation of the bruises to the hands in the record. A policy titled, PCC [Point Click Care--the electronic medical record program] Wound Documentation Protocol, received as current on 3/21/25 at 2:55 p.m. from the Unit Manager, indicated, . Weekly assessment of wounds and skin conditions will be documented weekly in the electronic medical record . Bruises and rashes may be evaluated using the skin and wound application or the non-pressure Ulcer Skin Condition Progress Report no later than every 7 days . When bruises are healing without complications . the nurse will monitor the site weekly. At the point of healing . the nurse will make a last entry in the medical record indicating the normal healing process has taken place without complications . 3.1-37(a)

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 03/21/2025
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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 10326 Based on observation, record review, and interview, the facility failed to ensure pressure reduction devices were in use for a resident with a pressure ulcer for 1 of 2 residents reviewed for pressure ulcers. (Resident 66) Finding includes: On 3/19/25 at 1:17 p.m. and 3:22 p.m., Resident 66 was observed in her room in bed. Her heel boots (a pressure reducing device) were observed on the chair next to the resident's bed. The resident's feet were not elevated while she was lying in bed. On 3/20/25 at 1:44 p.m. and 2:30 p.m., the resident was again observed in her bed. Her heel boots were in the chair, next to her bed and her feet were not elevated. The record for Resident 66 was reviewed on 3/19/25 at 10:07 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and dementia without behavior disturbance. The Admission Minimum Data Set (MDS) assessment, dated 1/10/25, indicated the resident was severely impaired for daily decision making, was dependent on staff for rolling left and right and for chair to bed transfers. The resident was not identified as having any pressure areas on the assessment. A Care Plan, dated 3/12/25, indicated the resident had a suspected deep tissue injury (a purple or maroon localized area of intact discoloration) to the left great toe. Interventions included, but were not limited to, float heels off of the mattress when in bed or wear heel off loading boots. A Physician's Order, dated 3/11/25, indicated the resident was to receive skin prep to her left great toe every shift. The Skin and Wound Evaluation, dated 3/17/25, indicated the resident had a deep tissue injury to her left great toe that measured length 0.9 centimeters (cm) by width 1 cm. During an interview on 3/21/25 at 1:44 p.m., the Wound Nurse was informed the resident's heel boots were not in use and/or her heels were not off loaded while she was in bed. The Wound Nurse indicated she would look into it. During an interview on 3/21/25 at 1:50 p.m., the Director of Nursing indicated the resident's heel boots should have been in use or her feet off loaded while she was in bed. 3.1-40(a)(2)

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 03/21/2025
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)

F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

40461

Based on interview and record review, the facility failed to ensure a resident, dependent on staff for transferring from the chair to bed, had received adequate assistance and supervision to prevent accidents related to staff not following the manufacture's manual regarding keeping the legs of the lift at their maximum opened position before lifting a resident during a mechanical lift transfer for 1 of 2 residents reviewed for accidents. (Resident 21) This deficient practice resulted in the resident falling and receiving a fracture to her left upper arm.

The deficient practice was corrected on 10/16/24, prior to the start of the survey, and was therefore past noncompliance. The facility identified the concern, completed a house wide sweep of the Hoyer lifts (a mechanical lift) and Hoyer slings, an inservice was held related to transfer techniques, two person staff assist while using the Hoyer lift, and leg of the base in their widest opened position, and return demonstration by staff was observed, and audits related to the use of the Hoyer lift were completed.

Finding includes:

During an interview on 3/17/25 at 2:13 p.m., Resident 21 indicated she had fallen when the Hoyer lift had tipped over. She indicated she had laid on her arm and had not gotten up until an ambulance arrived.

The record for Resident 21 was reviewed on 3/18/25 at 1:57 p.m. Diagnoses included, but were not limited to, fracture to the left humerus (upper arm) and need for assistance with personal care.

The Annual Minimum Data Set (MDS) assessment, dated 9/16/24, indicated the resident was cognitively intact, dependent on staff for transfers and had had no falls since the prior assessment.

A Quarterly Risk Evaluation Note, dated 9/16/24 at 3:31 p.m., indicated the resident was at moderate risk for a fall.

A Nurse's Note, dated 10/11/24 at 7:15 p.m., indicated the resident had fallen in her room. The CNA reported to the nurse the resident had fallen when they tried to put her to bed with the Hoyer lift. The nurse indicated she saw the Hoyer lift tipped on it's side on the resident's wheelchair, the resident was on the floor on her left side. The CNAs reported the wheel on the Hoyer lift had gotten stuck when they tried to get the resident in bed, when they moved the Hoyer, it had tipped over and the resident had fallen. The resident was crying, grimacing, and favored her left hand. The resident was sent to a local hospital emergency room for an evaluation and treatment. The immediate intervention indicated the Hoyer lift was moved off of the unit and maintenance was notified.

A Nursing progress note, dated 10/12/24 at 1:30 p.m., indicated the resident had returned to the facility at 8:40 a.m. She returned with the diagnoses of a contusion to her left elbow, a fracture to her left humeral head (upper arm), and a left wrist sprain. She had an order for Norco (an opioid pain medication) 5 mg (milligram) with 325 mg of acetaminophen every six hours as needed for pain.

(continued on next page)

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 03/21/2025
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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A Social Service progress note, dated 10/15/24 at 11:51 a.m., indicated the resident was encouraged to get out of bed as much as possible. The resident had reported having pain and some anxiety due to her recent fall. A Care Plan, dated 10/15/24, indicated the resident had a risk for falls related to a history of falls, use of psychotropic medications, involuntary movements, narcotic analgesics, and use of a mechanical lift. Interventions included, Hoyer lift for transfers. A Care Plan, dated 10/15/24, indicated the resident had a history of a traumatic fracture of the left shoulder. Interventions included, remind the resident about her weight bearing status to her affected extremity. During an interview on 3/20/25 at 9:03 a.m., CNA 5 indicated she had responded to Resident 21's room after hearing the call for assistance and she also indicated all staff had been re-trained on the use of the Hoyer lift. During an interview on 3/20/25 at 10:31 a.m., CNA 7 indicated she was the second staff member that had assisted with the transfer that resulted in the fall. She indicated a wheel on the lift got stuck on a wheel from the wheelchair and when they tried to turn the lift and it fell along with the resident and the other CNA. When the emergency medical personnel arrived, they assisted with getting the resident into the bed, then she was transferred to the emergency room . The CNA had been re-trained on use on the Hoyer lift and they were to keep the legs of the lift opened. A review of the investigation related to the fall, provided by the Director of Nursing on 3/20/25 at 11:32 a.m., included CNA 25's written statement, signed and dated 10/11/24, and indicated she had closed the legs of the Hoyer lift and pulled back the Hoyer, away from the wheelchair, when she turned the lift the wheelchair wheel got stuck on the Hoyer so she used her foot to pull the wheel over, all of the resident's weight went to one side, she tried to push the resident's weight back but couldn't and the Hoyer tipped over and the resident fell . During an interview on 3/20/25 at 11:38 a.m., the Administrator indicated the facility had the Hoyer lift go through preventative maintenance and nothing was found to be wrong with the lift. The facility had inserviced staff, performed competency skill checks, sling sizes, and began safety rounds. Documentation of facility inservices and subsequent auditing was reviewed and confirmed to be completed by 10/16/24. Staff interviews and observations also indicated adequate knowledge related to Hoyer lift transfers. The Hoyer lift manufacturer's recommendations included .Lift the Patient WARNING When using an adjustable base lift, the legs MUST be in the maximum Opened/Locked position before lifting the patient 3.1-45(a)(2)

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 03/21/2025
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43293 Based on observation, record review, and interview, the facility failed to ensure each resident requiring respiratory care received necessary services related to changing oxygen tubing for 1 of 4 residents reviewed for respiratory services. (Resident 44) Finding includes: During a random observation on 3/17/25 at 10:35 a.m., Resident 44 was observed sitting in her wheelchair. She was wearing a nasal cannula (a pronged tube that delivers oxygen through the nostrils), connected to a portable oxygen tank. The oxygen tubing was not dated. On 3/18/25 at 9:20 a.m., the resident was observed wearing her oxygen cannula. The oxygen tubing was not dated. The resident's record was reviewed on 3/18/25 at 2:17 p.m. Diagnoses included, but were not limited to, post-hip replacement, dementia, and muscle weakness. The 2/27/25 Admission Minimum Data Set (MDS) assessment, indicated the resident had severe cognitive impairment and was dependent in Activities of Daily Living (ADLs) and transfers. A Physician's Order, dated 2/25/25, indicated oxygen at 2 lpm (liters per minute) continuous, may titrate as needed. A Physician's Order, dated 3/11/25, indicated oxygen at 2 lpm continuous, may titrate for oxygen saturation less than 90% or shortness of breath. A Physician's Order, dated 3/19/25, indicated oxygen at 2 lpm per nasal cannula for oxygen saturation less than 90% or shortness of breath. A review of the eMAR (electronic medication administration record) indicated the resident used oxygen every day from 2/25/25 to 3/18/25. There was no documentation indicating the changing of the oxygen tubing. During an interview on 3/18/25 at 3:12 p.m., the Unit Manager for the 100 and 200 halls indicated oxygen tubing should be changed once a week if the oxygen was in use, and this change should be documented in the eMAR. A policy titled, Oxygen Administration, received as current on 3/21/25 at 1:57 p.m. from the Director of Nursing indicated, . Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated . 3.1-47(a)(6)

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 03/21/2025
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43293 Based on observation, record review, and interview, the facility failed to maintain the kitchen in a sanitary manner and in good repair related to lack of monitoring of freezer, refrigerator, and dishwasher temperatures and food not labeled and dated, for 1 of 1 kitchen. This had the potential to affect 86 of 87 residents who resided in the facility and received food from the kitchen. Findings include: During the Initial Kitchen Sanitation Tour on 3/17/25 at 8:47 a.m., with the Kitchen Manager, the following was observed: 1. There was no thermometer in the walk-in freezer. 2. There was no thermometer in the reach-in cooler. 3. The dishwasher temperature log was already filled out for breakfast, lunch and dinner time temperature checks for 3/17/25. 4. There was an unlabeled and undated tray of pre-filled cups of juice in the walk-in refrigerator. 5. The following items were found undated in the walk-in freezer: a bag of cookies, a bag of bread, a package of unidentified meat, a container of ice cream, a bag of ground sausage, and an open box of tropical freezes. 6. The following bagged items were found open, unlabeled and undated in the reach-in freezer: chicken breasts, potato wedges, and breaded chicken patties. During an interview on 3/17/25 at 9:20 a.m., the Kitchen Manager indicated the thermometer from the freezer must have fallen behind some boxes and they could not find it, and there should have been a thermometer in the reach-in cooler, but there was not. The temperature log for the dishwasher should have been filled out at the time each of the meal time checks were completed, and all food items should have been labeled and dated when opened. A policy titled Dishwasher Temperature, received as current from the Kitchen Manager on 3/18/25 at 2:53 p. m. indicated, . Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes. A policy titled Date Marking for Food Safety, received as current from the Kitchen Manager on 3/18/25 at 2:53 p.m. indicated, The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food . The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded . (continued on next page)

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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Pointe Health & Rehabilitation Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-21(i)(3)