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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Pointe Health & Rehabilitation Center	780 Dickinson Road Chesterton, IN 46304

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to ensure bruises were assessed and monitored for 2 of 3 residents reviewed for non-pressure related skin conditions, blood pressure medications were administered within parameters for 2 of 3 residents reviewed for medications with parameters, and an assessment was documented prior to and after an outpatient procedure for 1 of 3 residents reviewed for falls. (Residents 77, 48, 42, and 11)Findings include:1. The record for Resident 77 was reviewed on 5/4/26 at 1:34 p.m. Diagnoses included but were not limited to, stroke, dementia, fracture of right talus (ankle), major depressive disorder, and osteoarthritis of right and left knees. The Quarterly Minimum Data Set (MDS) assessment, dated 4/7/26, indicated the resident was moderately impaired for daily decision making. The resident had an impairment in range of motion to one side of his lower extremities and needed partial to moderate assist with transfers. An Outpatient Discharge Instruction sheet, dated 4/10/26, indicated the resident had a post medial branch block (spinal injection for pain management) at a surgery center. The instructions indicated not to shower until the next day and the bandage could removed the next day. There were no nursing progress notes regarding the procedure, when the resident left the facility, or when the resident came back to the facility. There was no assessment of the resident's bandage or an assessment of the resident's condition upon return. During an interview on 5/7/26 at 11:30 a.m., the Director of Nursing indicated there was no documentation or an assessment of the resident when he came back from his outpatient procedure. 2. During a random observation on 4/30/26 09:50 a.m., Resident 42 was observed with a dark purple bruise to the left antecubital (inner elbow) area. During random observations on 5/4/26 at 1:00 p.m., and 5/6/26 at 9:30 a.m., the dark purple bruise remained to the left antecubital area. The record for Resident 42 was reviewed on 5/6/26 at 1:21 p.m. Diagnoses included, but were not limited to, anxiety disorder, major depressive disorder, type 2 diabetes, heart failure, high blood pressure, and acute kidney failure. The 3/4/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A Care Plan, revised on 9/12/25, indicated the resident was at risk for abnormal bruising and bleeding related to the use of anticoagulant medication. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan, dated 3/30/26, indicated the resident had bruising to her upper extremities from needle sticks. Weekly Skin Observations, dated 4/23/26 and 4/30/26, indicated the resident had no bruises. A Skin/Wound Note, dated 5/1/26 at 1:22 p.m., indicated the resident had a new skin Issue under her left breast. Moisture associated skin damage (MASD) was observed under the breast with redness and excoriation. There was no documentation regarding any type of bruising to her left arm. During an interview on 5/7/26 at 9:15 a.m., the Director of Nursing indicated the resident had a blood draw on 4/28/26 and the weekly skin assessment indicated she had no bruising. 3. The record for Resident 48 was reviewed on 5/6/26 9:15 a.m. Diagnoses included, but were not limited to, type 2 diabetes, dementia, major depressive disorder, adult failure to thrive, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 2/4/26, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 9/10/25, indicated Metoprolol Tartrate tablet 50 milligrams (mg) give one tablet by mouth two times a day for high blood pressure and hold if pulse was less than 60. The Medication Administration Record (MAR) for the months of 11/2025, 12/2025, 1/2026, and 4/2026 indicated the Metoprolol was administered outside of the pulse parameters on the following days: 11/20/25: pulse was 55 12/27/25 pulse was 56 1/4/25: pulse was 57 and on 1/26/26 pulse was 52 4/15/26 pulse was 59, 4/25/26 pulse was 59, and on 4/26/26 pulse was 56 During an interview on 5/7/26 at 8:30 a.m., the Director of Nursing indicated the medication should have been held if his pulse was less than 60. 4. On 4/30/26 at 9:16 a.m. and 5/6/26 at 1:06 p.m., Resident 11 was observed lying in bed. There were 2 purple discolorations observed to her left forearm/wrist area and a purple discoloration with a black scab to her left hand. The resident's daughter was in the room; she indicated the discolorations had been there for a few days and she was unaware how the resident received them. Record review for Resident 11 was completed on 5/6/26 at 1:08 p.m. Diagnoses included, but were not limited to, heart failure, hypertension, orthostatic hypotension, and diabetes mellitus. The Significant Change MDS assessment, dated 4/6/26, indicated the resident was moderately cognitively impaired. The resident had an impairment on both sides of her upper and lower extremities (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for a functional limitation in range in motion. The resident was dependent on staff with dressing, bathing, and transfers. A Care Plan, dated 4/26/22 and revised 12/21/23, indicated the resident needed assistance with activities of daily living. An intervention included staff assistance with bed mobility, dressing, toileting, personal hygiene, and bathing. The Weekly Skin Assessment, dated 4/30/26, indicated the resident had no bruising. There was no documentation to indicate the resident's discolorations had been assessed or were monitored. During an interview on 5/6/26 at 1:12 p.m., QMA 1 indicated she was unaware the resident had any discolorations. During an interview on 5/6/26 at 1:12 p.m., LPN 3 indicated she was unaware the resident had any discolorations. A Care Plan, dated 2/28/25 and revised 4/3/26, indicated the resident was on hospice care related to congestive heart failure. An intervention included to administer medications as ordered. A Physician's Order, dated 10/24/25, indicated to administer midodrine hcl (medication to treat low blood pressure) 5 mg three times a day. Hold if systolic blood pressure (SBP, top number of blood pressure reading) was greater then 110. The April and May 2026 Medication Administration Records (MARs) indicated the midodrine was administered when the SBP was greater than 110 on the following dates and times:-4/3/26 at 1:00 p.m., the BP was 124/65 -4/3/26 at 5:00 p.m., the BP was 124/65-4/4/26 at 9:00 a.m., the BP was 120/67-4/5/26 at 1:00 p.m., the BP was 112/59-4/11/26 at 5:00 p.m., the BP was 117/64-4/23/26 at 9:00 a.m., the BP was 115/68-4/24/26 at 1:00 p.m., the BP was 122/76-4/26/26 at 5:00 p.m., the BP was 113/67-4/29/26 at 1:00 p.m., the BP was 112/72-5/5/26 at 5:00 p.m., the BP was 115/61 During an interview on 5/7/26 at 9:10 a.m., the Director of Nursing indicated she could not provide any documentation the resident's discolorations had been assessed or monitored or why the midodrine was administered outside of parameters. A facility policy titled, Skin Assessment and received as current from the facility on 5/7/26, indicated, .A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter.7. Documentation of skin assessment: b. Document observations (e.g. skin conditions). 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure medications were stored appropriately related to nystatin powder, insulin pens were not used past the expiration date, and over the counter medications were labeled correctly for 2 of 2 residents observed with medications in their rooms and for 2 of 4 medication carts observed. (Residents 42 and 9, the 100 hall and 400 hall medication carts)Findings include:1. During a random observation on [DATE] at 9:30 a.m., Resident 42 was observed in bed. At that time, there was a small plastic medication cup filled to the top of white powder on her dresser. During an interview at that time, the resident indicated the nurse had brought some Nystatin powder for her rash under her breasts and left it there so she could apply it herself. The record for Resident 42 was reviewed on [DATE] at 1:21 p.m. Diagnoses included, but were not limited to, anxiety disorder, major depressive disorder, type 2 diabetes, heart failure, high blood pressure, and acute kidney failure. The [DATE] Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no care plan indicating the resident could self-administer her own medications. A Care Plan, dated [DATE], indicated the resident had a skin integrity impairment under her breasts related to excessive moisture. A Skin/Wound Note, dated [DATE], indicated the resident had moisture associated skin damage (MASD) under the left breast. The wound bed was red and excoriated under the breasts. A Physician's Order, dated [DATE], indicated Nystatin Powder 100,000 units, apply under both breasts topically every day and evening shift for 14 days. There was no order to leave the powder in the resident's room so she could apply it herself. During an interview on [DATE] at 3:00 p.m., the Director of Nursing indicated the resident should have an order and an assessment to apply the powder herself. 2. During random observations on [DATE] at 9:34 a.m., 2:05 p.m., and 3:08 p.m., a bottle of nystatin (an anti-fungal) topical powder, was on Resident 9's bathroom counter next to the sink. It was labeled with Resident 9's name. The resident's record was reviewed on [DATE] 2:04 p.m. Diagnoses included, but were not limited to, osteoarthritis of the knee and cognitive communication deficit. The [DATE] Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and required assistance with ADLs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order, dated [DATE] and discontinued on [DATE], indicated nystatin powder to be applied to the groin every day. There was no order to keep the medication at the bedside. There was no current order for the medication. During an interview on [DATE] at 1:18 p.m., the Director of Nursing (DON) was informed of the findings and offered no additional information. 3. During an observation of the 100 hall medication cart on [DATE] at 10:31 a.m., an insulin pen labeled with an expiration date of 4/22 was observed. At that time, RN 2 indicated the insulin pen should not be in the cart, and she would dispose it. 4. During an observation of the 400 hall medication cart on [DATE] at 10:55 a.m., the following was observed: a. An insulin pen was labeled opened on 4/6, expired on 5/4. LPN 3 indicated she could not tell if the written expiration date was 5/4 or 5/9 and she was unsure how long after opening it expired, they were always changing it. She then used a marker and changed the expiration date on the insulin to 5/9. b. A small medication bottle containing tablets was in a patient's medication drawer. TUMS was hand-written on the bottle. There was no other label or identifying information of the contents. At that time, LPN 3 indicated they were Tums (antacid medication), brought in for a resident by their family. LPN 3 indicated medications brought in by family were supposed to be labeled with the resident's name. She then wrote a resident's last name on the bottle and returned it to the drawer. During an interview on [DATE] at 1:18 p.m., the DON indicated insulin pens should be discarded 28 days from opening. A Policy titled, Labeling of Medications and Biologicals, received from the Administrator as current on [DATE] at 2:53 p.m., indicated, . 7. Labels for over-the-counter (OTC) medications must include: a. The original manufacturer's or pharmacy-applied label indicating the medication name; b. The strength, quantity, lot, and control number; c. The expiration date when applicable; d. Appropriate accessory and precautionary statements; e. Directions for use. 8. Labels for multi-use vials must include: a. The date the vial was initially opened or accessed (needle-punctured) . b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial . 410 IAC (Indiana Administrative Code)16.2-3.1-25(j) 410 IAC (Indiana Administrative Code)16.2-3.1-25(o)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to maintain a resident's dignity related to checking a resident's blood sugar and announcing the result in a common area for 1 of 2 residents reviewed for dignity. (Resident 97)Finding includes:During an observation on 5/1/26 at 11:21 a.m., RN 1 was preparing to check Resident 97's blood sugar. The resident was sitting in her wheelchair in the day room along with two other residents and a visitor. RN 1 approached the resident, and told her she was going to check her blood sugar. She stuck the resident's finger, checked her blood sugar, and announced the result loudly. RN 1 did not ask the resident permission to check her blood sugar in the common area with others present. During an interview on 5/1/26 at 11:43 a.m., Unit Manager 1 indicated the resident was alert and oriented, and new to the facility. They were working on a care plan that indicated the resident was ok with having her blood sugar checked in common areas. When informed that RN 1 did not ask the resident's permission and that she announced the results loudly with other residents and a visitor present, no additional information was received. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(t)

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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. Based on observation, interview, and record review, the facility failed to ensure residents who were dependent on staff for Activities of Daily Living (ADLs) received the care and assistance needed related to trimming their fingernails for 2 of 7 residents reviewed for ADLs. (Residents 7 and 57)Findings include: 1. On 4/29/26 at 10:37 a.m., and again on 5/4/26 at 1:10 p.m., Resident 7 was observed lying in bed. The resident's fingernails were long, thick, and yellowed. The resident indicated she would like someone to cut her fingernails but had been told they could not cut them because she had a fungus in them. Record review for Resident 7 was completed on 5/4/26 at 9:47 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis on one side of the body) and depression. The Annual Minimum Data Set (MDS) assessment, dated 3/10/26, indicated the resident was cognitively intact. The resident had an impairment on one side of her upper extremities for a functional limitation in range of motion. The resident required substantial maximal assistance for personal hygiene. A Care Plan, dated 6/29/22 and revised 3/13/26, indicated the resident required assistance with ADLs related to having a stroke with hemiplegia to her left side. An intervention included staff assistance for personal hygiene. There was a lack of documentation to indicate the resident's fingernails had been trimmed or was offered to have them trimmed. During an interview on 5/4/26 at 1:13 p.m., LPN 2 indicated she was unsure why the resident's fingernails had not been trimmed. The nurses or the CNAs should trim the resident's nails when needed. During an interview on 5/4/26 at 1:17 p.m., the Director of Nursing (DON) indicated the resident had been treated before for the fungus in her nails. The staff should include trimming fingernails in the resident's ADL care and should have offered to cut the resident's fingernails. A facility policy titled, Activities of Daily Living (ADLs) and received as current from the facility on 5/7/26, indicated, .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; . 2. During random observations on 4/30/26 at 9:55 a.m., 5/1/26 at 9:45 a.m., and 5/4/26 at 9:04 a.m., Resident 57 was observed resting in bed. Her left arm was flaccid (lacking muscle tone, limp), and the fingernails on her left hand were very long. The resident's record was reviewed on 5/1/26 at 10:47 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis of one side of the body) following a stroke, need for assistance with personal care, and generalized muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 4/17/26, indicated the resident was cognitively intact for daily decision making, had functional limitation in range of motion on one side, and was dependent in ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, revised on 1/20/26, indicated the resident had hemiplegia on her left side due to a stroke. Interventions included staff to assist with ADLs. During an interview on 5/4/2026 at 9:04 a.m., the resident indicated she did not want her fingernails on her left hand to be that long and wanted them cut. During an interview on 5/4/2026 at 1:56 p.m., the DON was informed of the findings and offered no further information. 410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3)(E)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, record review, and interview, the facility failed to provide activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 1 of 2 residents reviewed for activities. (Resident 22)Finding includes:During random observations at the following dates and times, Resident 22 was observed lying in bed, the room quiet without television, music, or other stimulation: 4/29/26 at 11:31 a.m., 4/30/26 at 10:16 a.m. and 3:16 p.m., 5/1/26 at 10:13 a.m. and 2:53 p.m., 5/4/26 at 9:51 a.m., and 5/6/26 at 11:20 a.m. On 5/1/26 at 2:15 p.m., an activities event with live music was observed in the main dining room. Resident 22 remained in his quiet room, awake in bed.The record for Resident 22 was reviewed on 5/4/26 at 10:14 a.m. Diagnoses included, but were not limited to, Parkinson's Disease and cerebrovascular disease.The Quarterly Minimum Data Set (MDS) assessment, dated 2/10/26, indicated the resident had moderate cognitive impairment and was dependent in ADLs and transfers.An Activities Care Plan, revised 4/27/26, included the intervention that staff should invite the resident to groups of interest such as worship, music events, social groups and cognitive groups. The May 2026 Activities Calendar indicated a music activity on 5/3, art activities on 5/4, 5/5, and 5/6, and worship activities on 5/1, 5/2, and 5/3.The Activities Participation 30-day documentation indicated in the resident had received three one-on-one visits per week, one friendly visit, and one people watching. There was no documentation of the resident attending or refusing activities.During an interview on 5/6/26 at 2:18 p.m., the Activities Director indicated the resident liked music and art. He used to participate in activities with assistance, but had not been out of his room for an activity since March. She did not recall him refusing activities, but that it could take a lot of work to get residents into activities. The only activity interaction he was receiving was three 20-30 minute long one-to-one visits per week. When informed of the findings, the Activities Director indicated they would try to get the resident out more and provide more ongoing stimulation, like music, while in his room. 410 IAC (Indiana Administrative Code)16.2-3.1-33(a)

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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. Based on observation, record review, and interview, the facility failed to provide oxygen at the correct flow rate and with protective padding as ordered for 1 of 1 resident reviewed for respiratory care. (Resident 22)Finding includes:During random observations on 4/30/2026 at 10:16 a.m. and 2:07 p.m., and 5/4/2026 at 9:50 a.m., Resident 22 was resting in bed. Oxygen was in use via a nasal cannula (small, soft prongs that go into the nostrils) at 3.5 lpm (liters per minute). There was no padding in place on the cannula tubing. The record for Resident 22 was reviewed on 5/4/26 at 10:14 a.m. Diagnoses included, but were not limited to, Parkinson's Disease, pneumonia, chronic respiratory failure, and dependence on supplemental oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 2/10/26, indicated the resident had moderate cognitive impairment and was dependent for activities of daily living (ADLs). A Physician's Order, dated 3/24/2026, indicated oxygen at 4 lpm per nasal cannula, continuously. A Physician's Order, dated 3/26/2026, indicated padding to oxygen tubing, ensure in place, and reapply as needed, every shift. A Care Plan, revised on 5/17/2024, indicated the resident had a change in his respiratory status related to emphysema (lung disease). Interventions included providing oxygen as ordered.During an interview on 5/4/2026 at 9:56 a.m., LPN 1 confirmed there was no padding on the cannula tubing, and the oxygen flow rate was set at 3.5 lpm, but should have been at 4 lpm. 410 IAC (Indiana Administrative Code) 16.2-3.1-47(6)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and a system of monitoring to improve resident outcomes and reduce antibiotic resistance related to a practitioner prescribing antibiotics for not true infections based on the McGeer Criteria (standardized definitions used for urinary tract infection (UTI) surveillance in long-term care, requiring both specific symptoms and microbiologic evidence) for 2 of 3 residents reviewed for urinary tract infections. (Residents 42 & 5)Findings include:1. During an interview on 4/30/26 at 9:50 a.m., Resident 42 indicated she has had frequent Urinary Tract Infections (UTI's) and as soon as the antibiotic was completed, the symptoms start again. During an interview on 5/6/26 at 9:30 a.m., the resident indicated she had seen an Urologist and had a procedure, however, she got sick with COVID and has not had the follow up appointment. She still would like to see this physician. The record for Resident 42 was reviewed on 5/6/26 at 1:21 p.m. Diagnoses included, but were not limited to, anxiety disorder, major depressive disorder, type 2 diabetes, heart failure, high blood pressure, and acute kidney failure. The 3/4/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was occasionally incontinent of urine.The Care Plan, dated 5/4/26, indicated the resident had an acute Urinary Tract Infection and required the use of oral antibiotic therapy. A Nurse's Note, dated 3/16/26 at 7:10 p.m., indicated an order was received from the Nurse Practitioner (NP) for an urinalysis (UA) with a culture and sensitivity for agitation. The resident was notified the next time she went to the bathroom, to let the staff know so they can collect the urine sample. An NP Note, dated 3/17/26 at 4:32 p.m., indicated the NP reviewed the UA that was ordered by the psychiatric NP. The resident previously had Extended-Spectrum beta lactamase (ESBL) in the urine with 2 organisms and ended up on IV antibiotics in 1/2026. Will get a midline inserted and wait for final culture to treat.The UA report, dated 3/17/26, indicated the resident's urine color was clear and dark yellow and was negative for blood and nitrates. The urine had a large amount of leukocytes and a trace of bacteria. The preliminary findings was 10-50,000 gram negative bacilli.A Nurse Practitioner (NP) Note, dated 3/18/26 at 11:28 a.m., indicated the resident was seen for a high risk follow up visit and had a midline placed last night in anticipation of IV antibiotics starting for UTI. The resident had a cystoscopy (procedure using a camera to view the bladder) with an urologist on 1/23/26 and was told to follow up in 4-6 weeks. The staff reported the resident had an urinalysis ordered by the contracted behavioral agency for agitation and the patient also had previously reported frequency and urgency.A Nurse's Note, dated 3/18/26 at 1:12 p.m., indicated the urine showed few bacteria, the NP was aware, and awaiting the final culture. A Physician's Order, dated 3/19/26, indicated IV Meropenem solution 1 gram every eight hours for a complicated UTI for seven days.The Medication Administration Record (MAR) for 3/2026, indicated the resident received the IV antibiotic on 3/19/26 at 9:00 a.m. through 3/26 at 1:00 a.m.A NP Note, dated 3/21/26 at 7:50 p.m., indicated the final culture was reviewed final culture and Meropenem was susceptible, so no changes needed to the IV antibiotic regime.The final culture, dated 3/21/26, indicated the resident had 10-50,000 colonies of Proteus Mirabilis not ESBL.There was no documentation by the NP why the resident continued on the IV antibiotic after the final culture results. There was no documentation the resident had any physical signs or symptoms of an UTI. The resident was to follow up in four weeks with the urologist, however she contracted COVID on 2/22/26 and was moved to isolation. A Nurse's Note, dated 3/10/26 at 4:47 p.m., indicated the resident cancelled her appointment with the Urologist. The resident indicated she was not ready and her son was made aware. An NP Note, dated 4/27/26 at 10:22 a.m., indicated the resident reported she had a sore bladder and was peeing razor blades with frequency. A Nurse's Note, dated 4/27/26 at 11:18 p.m., indicated a urine sample (UA) was collected and placed in the refrigerator. The UA report, dated 4/27/26, indicated the urine color was clear and dark yellow. The UA was negative for nitrates, (continued on next page)

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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Pointe Health & Rehabilitation Center	780 Dickinson Road Chesterton, IN 46304

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had a large amount leukocytes, with moderate bacteria.A Nurse's Note, dated 4/30/26 at 3:30 p.m., indicated the preliminary UA culture showed 10-50,000 gram negative bacilli. The NP was notified and indicated she would wait for the final culture. The final culture results, dated 5/1/26, indicated the organism of Morganella morganii 10-50,000 colonies was present. A Physician's Order, dated 5/1/26, indicated Levaquin oral tablet 250 milligrams (mg), give one tablet by mouth at bedtime for UTI for 10 days.The MEdication Administration Record (MAR) for 5/2026, indicated the Levaquin was administered from 5/1-5/6/26.There was no documentation from the NP on why the antibiotic was ordered nor was there any documentation the resident continued to have signs and symptoms of an UTI such as burning, pain, and frequency. During an interview on 5/7/26 at 8:30 a.m., the Director of Nursing indicated there was no documentation from the NP on why the resident was started on an antibiotic in 4/2026. The culture did not meet McGeer's criteriaDuring an interview on 5/7/26 at 9:30 a.m., the Nurse Consultant indicated the NP had ordered the IV antibiotic prior to the culture results and the final culture did not meet McGeer's criteria. 2. The record for Resident 5 was reviewed on 5/4/26 at 11:30 a.m. The resident was admitted on [DATE] and her diagnoses included, but were not limited to, acute cystitis, bacteremia, high blood pressure, dementia, disorders of the kidney and ureter, acute kidney failure, chronic kidney disease, heart failure, anxiety, retention of urine, neuromuscular of bladder, urinary tract infection (UTI), and Extended-Spectrum beta lactamase (ESBL).The admission Minimum Data Set (MDS) assessment, dated 3/21/26, indicated the resident was moderately impaired for daily decision making, and was always incontinent of bladder. A 4/13/26 Nurse Practitioner (NP) Note indicated the resident was being seen for staff and family concerns of the resident not eating or drinking well. The resident reported no appetite and was nauseated at times with some dizziness. Labs and IV fluids were ordered.A Nurse's Note, dated 4/15/26 at 6:03 p.m., indicated the family requested an urinalysis (UA) with a culture and sensitivity to rule out an infection. The NP was notified and a new order was received. A Nurse's Note, dated 4/16/26 at 7:12 p.m., indicated the UA results were received and the resident's urine color was yellow with a moderate amount of blood noted. The urine was positive for nitrates, many bacteria and a moderate amount of Leukocytes. The on call NP was notified and no new orders were received. A Physician's Order, dated 4/17/26, indicated Cipro tablet 500 milligrams (mg), give one tablet by mouth two times a day for infection.The 4/2026 Medication Administration Record (MAR) indicated the Cipro was administered on 4/17 at 5:00 p.m. and 4/18 at 9:00 a.m. The final culture results, dated 4/18/26, indicated Escherichia coli (ESBL) 10-50,000 colonies. The sensitivity results indicated the organism was resistant to Cipro. A Nurse's Note, dated 4/18/26 at 3:26 a.m., indicated the Medical Assistant was notified and instructed the facility to fax over the results and the on call NP would call back with any new orders if needed.A Nurse's Note, dated 4/18/26 at 3:28 a.m., indicated the on call NP called back and indicated no new orders at this time, just place lab results in binder for NP to review.A Nurse's Note, dated 4/18/26 at 10:46 a.m., indicated the NP was notified of the final culture results and orders were received to discontinue the Cipro antibiotic and follow up with the NP on Monday if the resident becomes symptomatic. A Physician's Order, dated 4/23/26, indicated Macrobid (an antibiotic) oral Capsule 100 mg, give one capsule by mouth every 12 hours for UTI/ESBL for seven days.The 4/2026 MAR indicated the Macrobid was administered to the resident on 4/24/26 through 4/30/26.There was no documentation from the NP on why the antibiotic was ordered nor was there any documentation the resident continued to have signs and symptoms of an UTI such as burning, pain, and frequency. During an interview on 5/7/26 at 8:30 a.m., the Director of Nursing indicated the NP just ordered the Macrobid because of the ESBL and had no documentation of why it was ordered when it did not meet McGeers criteria. There was no documentation the resident had any signs or symptoms of an UTI.The current McGeer Criteria policy, provided by the Administrator on 5/7/26 at 12:59 p.m., UTI without indwelling catheter must fulfill both 1 and 2.ˆ 1. At least one of the following sign or symptomˆ Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostateˆ Fever or leukocytosis, and ˆ 1 of the following:ˆ Acute costovertebral angle pain or tendernessˆ (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Suprapubic painˆ Gross hematuriaˆ New or marked increase in incontinenceˆ New or marked increase in urgencyˆ New or marked increase in frequencyˆ If no fever or leukocytosis, then ˆ 2 of the following:ˆ Suprapubic painˆ Gross hematuriaˆ New or marked increase in incontinenceˆ New or marked increase in urgencyˆ New or marked increase in frequencyˆ 2. At least one of the following microbiologic criteriaˆ ˆ 105 cfu/mL of no more than 2 species of organisms in a voided urine sampleˆ ˆ 102 cfu/mL of any organism(s) in a specimen collected by an in-and-out catheterIAC (Indiana Administrative Code) 16.2-3.1-18(b)(1)