

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2025
NAME OF PROVIDER OR SUPPLIER Northwest Manor Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34th St Indianapolis, IN 46224	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</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

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide or document showers for 2 of 3 residents reviewed for bathing preferences (Residents B, and H). Findings include: 1. During an interview on 7/21/25 at 10:15 a.m., Resident Representative 1 indicated Resident B had not received a shower for the past year, until after the family had complained and met with administrative staff. A Resident/Family Concern Form, dated 6/22/25 at 11:30 a.m., indicated Resident Representative 1 verbalized to the Weekend Supervisor she had a concern regarding Resident B not getting showers. The resolution, dated 6/23/25, indicated the resident got a shower and staff were educated on the use of a shower bed. On 7/21/25 at 11:00 a.m., Certified Nursing Assistant (CNA) 6 and an unidentified female staff member were observed using a mechanical lift to transfer Resident B out of bed into a specialized tilt and recline wheelchair. Resident B was observed to be wearing a green dress, black cap over her braided hair, a beaded bracelet, and gray socks. CNA 6 indicated he had not recently cared for the resident, but he was filling in and Resident B was on his assignment list to give a bath. On 7/22/25 at 9:15 a.m., Resident B was observed lying flat on her back in bed, eyes opened and covers to her chest. The resident was wearing a bright yellow tunic/dress and a beaded bracelet on her right wrist. The resident's braided hair was observed to be flattened and frizzy, it did not look as if it had been recently braided. The resident indicated she liked getting showers but did not remember if she'd had one recently. Resident B's clinical record was reviewed on 7/21/25 at 2:00 p.m. Resident B was admitted on [DATE] with diagnoses to include vascular dementia, hemiplegia and hemiparesis (paralysis on one side of the body) following a cerebral infarction affecting the left non-dominant side, morbid obesity, and dysphasia (neurological disorder that affects the ability to understand, produce, or use language). The annual MDS (Minimum Data Set) assessment, completed on 6/27/25, assessed Resident B as having severe cognitive impairment, and she B was dependent on staff for bathing, showers, and toileting. The resident utilized a mechanical lift for transfers and was propelled by staff in a manual wheelchair. It was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. A Preferences for Customary Routine and Activities assessment, dated 6/24/25, indicated it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. The assessment lacked documentation of Resident B's preference(s). A care plan, dated 6/22/24, indicated the resident liked to choose bathing options, what to wear, listening to religious music, watching tv/comedies, and usually to be up by 10:00 a.m., and in bed by 3:00 a.m. Resident B's goal was to have her preferences met daily, and the approach was to be offered bathing options and what to wear. A Care Plan Attendance Forms with dates of 4/29/25 and 6/30/25 were signed as the plan of care meeting expectations and issues addressed. There was no documentation to describe what the issues might have been, how the issues were resolved, and no care plan update. CNA Assignment Sheets indicated Resident B was scheduled for showers on Wednesday and Saturday day shift. A typed note, dated 6/30/25, indicated in-service for all staff and Resident B specifically, included, Make sure the resident is getting her showers on Wednesday and Saturday day shift. Use the soap/hygiene products in her room. Use a Hoyer pad and shower bed. When the shower is done and the resident returns to her room, place 3-4 towels on the bed before lying the resident on the mattress. Once the resident is in bed, remove the towels and continue care. On shower days, the night CNA should not dress the resident, leave her in a gown since a shower will be done. The family prefers regular clothes instead of gowns Point of Care (POC - electronic documentation system) History report, indicated the resident was totally dependent on staff for bathing, showers, toilet use, and personal hygiene. The report indicated there was no documentation for showers or refusal of showers from 6/20/24 to 6/25/25. During an interview on 7/21/25 at 2:39 p.m., CNAs 10 and 11 indicated Resident B's shower day was documented in the shower book and on the daily CNA assignment sheet. During an interview on 7/21/25 at 2:43 p.m., Licensed Practical Nurse (LPN) 5 indicated Resident B had some confusion and did not always make her own decisions. Shower preferences were documented during care plan conferences between the resident/resident representative, Unit Manager (UM), and Social Service Director (SSD). If a resident could not make their own decisions, then the staff would follow family preference decisions to provide care. If a resident was combative and refused care or showers, that behavior would be documented, the refusals discussed with family, and care plan decisions documented. During an interview on 7/21/25 at 3:12 p.m., UM 1 indicated she shared duties with another nurse on a rotating schedule. Both nurses were responsible for attending care plan</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care plan interventions were personalized and updated to include changes in shower preferences for 2 of 3 residents reviewed for bathing preferences (Residents B, and H). Findings include:1. During an interview on 7/21/25 at 10:15 a.m., Resident Representative 1 indicated Resident B had not received a shower for the past year, until after the family had complained and met with administrative staff. A Resident/Family Concern Form, dated 6/22/25 at 11:30 a.m., indicated Resident Representative 1 verbalized to the weekend supervisor she had a concern regarding Resident B not getting showers. The resolution, dated 6/23/25, indicated the resident got a shower and staff were educated on the use of a shower bed.On 7/21/25 at 11:00 a.m., Certified Nursing Assistant (CNA) 6 and an unidentified female staff member were observed using a mechanical lift to transfer Resident B out of bed into a specialized tilt and recline wheelchair. Resident B was observed to be wearing a green dress, black cap over her braided hair, a beaded bracelet, and gray socks. CNA 6 indicated he had not recently cared for the resident, but he was filling in for staffing today and had Resident B on his assignment list to give a bath.Resident B's clinical record was reviewed on 7/21/25 at 2:00 p.m. Resident B was admitted on [DATE] with diagnoses to include vascular dementia, hemiplegia and hemiparesis (paralysis on one side of the body) following a cerebral infarction affecting the left non-dominant side, morbid obesity, and dysphasia (neurological disorder that affects the ability to understand, produce, or use language). A Preferences for Customary Routine and Activities assessment, dated 6/24/25, indicated it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. The assessment lacked documentation of Resident B's preferences. A care plan, dated 6/22/24, indicated the resident liked to choose bathing options, what to wear, listening to religious music, watching tv/comedies, and usually to be up by 10:00 a.m., and in bed by 3:00 a.m. Resident B's goal was to have her preferences met daily, and the approach was to be offered bathing options and what to wear. The care plan lacked documentation of chosen bathing options. A Care Plan Attendance Form with dates of 4/29/25 and 6/30/25 was signed as the plan of care meeting expectations and issues addressed. There was no documentation to describe what the issues might have been, how the issues were resolved, and no care plan update. Observation of CNA Assignment Sheets indicated Resident B was scheduled for showers on Wednesday and Saturday day shift.During an interview on 7/21/25 at 2:43 p.m., Licensed Practical Nurse (LPN) 5 indicated, Resident B had some confusion and did not always make her own decisions. Shower preferences were documented during care plan conferences between the resident/resident representative, Unit Manager (UM), and Social Service Director (SSD). If a resident could not make their own decisions, then the staff would follow family preference decisions to provide care. If a resident was combative and refused care or showers, that behavior would be documented, the refusals discussed with family, and care plan decisions documented. During an interview on 7/21/25 at 3:12 p.m., UM 1 indicated she shared duties with another nurse on a rotating schedule. Both nurses were responsible for attending care plan conferences for Wings 1 and 2, dependent on who was working. UM 1 indicated, Resident B's resident preference form had been completed, but it was vague. Resident bathing preferences should have been on the care plan and then linked to the CNA profile. A resident preference could also be set up to be clicked off/documentated as completed on POC. All department heads or department representatives had the capability to add resident specific wishes on the care plan. If a confused resident was refusing care the family had specified, then a conversation would be had with the family to try and resolve, and the conversation and outcome would be documented in the resident record.2. On 7/21/25 at 10:55 a.m., Resident H was observed lying in a bariatric bed watching television. The resident indicated she liked getting a shower and thought she'd had one last week.On 7/22/25 at 9:24 a.m., Resident H was observed lying in the bed listening to a portable boom box. The resident indicated that she liked getting a shower and her hair washed, and she was supposed to be getting a shower that day. The resident indicated she was unable to stand to transfer, and the staff had to Hoyer her to the shower chair.Resident H's clinical record was reviewed on 7/21/25 at 2:59 p.m. Diagnoses on the resident's profile included, encephalopathy (a group of conditions that cause brain dysfunction) and obesity.A Preferences for Customary Routine and Activities assessment, dated 5/23/25, indicated it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. The assessment lacked documentation of Resident H's preferences. A care plan dated 6/20/23 indicated the resident liked to choose bathing options, ward searches, hino</p>		