STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155041	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwest Manor Health Care Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. On 6/9/25 at 9:24 a.m., a record review was completed for Resident 25. She had the following diagnoses which included but were not limited to chronic kidney disease, heart failure, high cholesterol, hypertension and overactive bladder. Her most recent Minimum Data Set (MDS) quarterly assessment indicated she had a fall with major injury. Resident 25's record lacked documentation of a fall with major injury. On 6/9/25 at 1:20 p.m., during an interview, the Director of Nursing (DON) indicated Resident 25 only had one fall on 4/25/25 and it did not result in an injury. On 6/9/25 at 2:00 p.m., during an interview, the MDS Coordinator indicated it must have been an entry error, and she would correct it. On 6/10/25 at 10:40 a.m. the Executive Director provided a copy of a current facility policy titled, MDS Error Correction undated. This policy only discussed what staff was to do if an error was discovered by a facility staff member, and how to correct the error. Based on observation, interview, and record review, the facility failed to accurately code a resident's fall status for 1 of 21 residents reviewed for assessment accuracy (Resident 25). Findings include:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct a thorough skin assessment upon admission to identify and put a pressure ulcer treatment in place for 1 of 6 residents reviewed for pressure ulcers (Resident 100). Findings include: During an interview on 6/5/25 at 12:17 p.m., Resident 100's family member indicated several days after the resident admitted to the facility, they got a call from the facility to inform them there was a large wound on the back of the resident's head. From what the facility told them, the resident's hair was badly matted at the back of her head and when the staff went to wash her hair they noticed this wound. The family member indicated the resident had been in the hospital for nearly a month after her stroke, was unable to move at all, and kept on her back, so the wound started at the hospital. On 6/5/25 at 2:00 p.m., Resident 100 was observed. She was seated in a broda chair in the therapy gym. She was alert to her surroundings, but unable to hold a conversation. She was able to shake her head yes or no to answer questions and smiled at jokes. On 6/5/25 at 2:30 p.m., Resident 100's medical record was reviewed. She admitted to the facility on [DATE] with diagnoses which included, but were not limited to cerebral infarction (stroke) which resulted in full body hemiparesis/hemiplegia (muscle weakness/paralysis) and total dependence for all activities of daily living (ADLs). An admission nursing assessment, dated 4/22/25 at 1:03 a.m., indicated Resident 100 did not have any pressure ulcers upon her admission on [DATE]. An admission full body assessment, dated 4/22/25 at 12:30 a.m., indicated Resident 100 did not have any pressure ulcers upon her admission on [DATE]. An admission nursing progress note, dated 4/22/25 at 2:05 a.m., indicated Resident 100 was noted to have excoriation on her right thigh, bruises to her abdomen and the left thigh, a small laceration on the right inner elbow, and additional bruises on both her upper extremities. She required tube feeding for nutrition and was bedbound. A nursing progress note, dated 4/22/25 at 4:10 a.m., indicated Resident 100 was unable to move and had to be turned every two hours. A Physician Services progress note was documented late on 4/29/25 at 9:57 a.m., made effective for 4/24/25 at 9:57 a.m. The Physician visit was for an acute concern related to a wound on the back of the resident's head. Acute visit for wound. Therapies expressed concern over new wound after attempting to brush out matted area to back of head. Upon further inspection, found 5.5 x [by] 4.3 cm [centimeters] necrotic area with slough noted underneath . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 4/24/25 at 4:00 p.m., indicated Resident 100 admitted to the facility on [DATE] with several skin impairments which included, but was not limited to, .area that appears to be related to pressure to back of head The wound team was notified and treatments were put in place. A new skin event titled, Skin Integrity Events - Pressure Sore/Statis Ulcer was opened on 4/24/25 at 3:19 p. m. and indicated Resident 100 had a new unstageable pressure ulcer (a pressure ulcer where the base of the wound is obscured by slough [yellow, tan, grey, green, or brown tissue] and/or eschar [tan, brown, or black tissue] which prevents a healthcare professional from accurately assessing the depth and true stage of the ulcer), to the back of her head which measured 5.5 cm long by 4.3 cm wide. A new treatment order was put in place to cleanse posterior occiput (back of head) with NS (normal saline), apply Santyl to necrotic area and cover with non-adherent dressing, secure with kerlix. Treatment was to do done every day and as needed (PRN) if soilage or dislodgement. A Wound Doctor and Interdisciplinary Team (IDT) progress note, dated 4/29/25 at 8:38 a.m., indicated Resident 100 was seen on wound rounds on 4/28/25 for an initial assessment. The wound doctor classified the wound as an unstageable pressure ulcer and proceeded to debried the wound. After the debridement procedure, the wound was reclassified as a stage IV pressure ulcer (full-thickness tissue loss with exposure of muscle, tendon, or bone) with a goal to heal. The Wound Doctor updated the treatments orders to, cleanse wound to posterior head with wound cleanser, pat dry and apply honey, then pack lightly with fluffed gauze as needed, cover with bordered gauze. Change daily and as needed. During an interview on 6/9/25 at 11:32 a.m., the Wound Doctor indicated he could not confirm the wound was acquired at the hospital because it was not identified or documented on any of her hospital records. At the time of his initial assessment, judging by the condition of the wound, it was most likely acquired at the hospital and was just missed on the facility's nursing admission assessments. After the wound was identified, she received routine treatments and was healed out during his visit that morning (6/9/25). On 6/9/25 at 11:45 a.m., the Administrator provided a copy of current but undated facility policy titled, Resident Skin Assessment Upon Admission. The policy indicated, Purpose: to ensure a thorough skin assessment is performed on each resident upon admission to identify existing conditions, prevent pressure injuries . The facility shall perform a comprehensive skin assessment on each resident within 24 hours of admission . The goal is early identification of ant existing wounds or skin integrity issues and prompt implementation of preventative and therapeutic interventions . conduct a full head-to-toe visual skin inspection 3.1-40(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall interventions were in place as outlined in the residents' plan of care for 3 of 4 residents reviewed for falls (Residents 88, 96, and 85). Findings include: 1. On 6/5/25 at 2:22 p.m., Resident 88 was observed in the main dining room during a group activity. She was seated in a wheelchair and although she had a personal storage pouch, it was attached to the back of her wheelchair out of reach. She was not observed to have a reacher. On 6/9/25 at 8:35 a.m., Resident 88 was observed. She was seated in her wheelchair in the main dining room, in front of the nurses' station. Her eyes were closed and there was a stack of papers and a word search booklet which rested on her lap. Upon approach and calling her name, she raised her head and opened her eyes as the stack of papers began to slide from her lap. Resident 88 did not have a reacher. The personal storage pouch was attached to the back of her chair. Resident 88 indicated she must have nodded off asleep while she waited for the housekeepers to finish sweeping in the dining room. She indicated she was tired and wouldn't mind a nap. Resident 88 indicated she had a couple falls from out of her wheelchair because she would attempt to lean forward and reach for things that fell. She indicated she had a reacher before but did not know where it was and that it had been missing for a while. She indicated she did have a personal storage pouch but it was on the back of her wheelchair, and she could not reach it, when asked if staff would assist her to get things or put things away, she indicated, I ask, but you know how that goes. They are so busy, I don't bother them with the small stuff. A plastic chair alarm was observed underneath her pressure reducing cushion and when asked if that caused her cushion to slide, she demonstrated he ability to slough down and slide forward in the seat. She was able to reposition herself back up to an upright position and indicated, I try not to do that because I've learned the hard way. During a continuous observation from 6/9/25 at 8:40 a.m., until 9:00 a.m., Resident 88 was left unsupervised by nursing staff in the main dining room as two housekeepers swept, mopped, and wiped down tables. On 6/9/25 at 8:10 a.m., Resident 88's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, repeated falls, fracture of first and third lumbar vertebra and fracture of mandible (jaw). A nursing progress note, dated 9/19/24 at 6:28 p.m., indicated Resident 88 had been in the dining room with a peer when a loud noise was heard. Resident 88 was found on the floor with her face down. She was assisted back into her wheelchair with help from staff and taken back to her room where she was assessed and found to have sustained a skin tear to the middle of her nose and a hematoma to her forehead. Her vital signs and neuro checks were within normal limits, and the doctor was notified. An Interdisciplinary team (IDT) progress note, dated 9/20/24 at 12:35 p.m., indicated Resident 88 had an unwitnessed fall in the dining room after she attempted to reach something on the floor. A new intervention was put in place to ensure she was not left unattended in the dining room. Her care plan was updated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing progress note, dated 1/11/25 at 7:29 p.m., indicated Resident 88 was found on the floor after she attempted to transfer from her wheelchair into her bed. An IDT progress note, dated 1/13/25 at 7:08 p.m., indicated a new intervention for fall prevention was to ensure Resident 88 was laid down after meals. Her care plan was updated. A nursing progress note, dated 5/11/25 at 6:51 p.m., indicated Resident 88 fell form her wheelchair while she was sitting in the dining room and she attempted to pick up an item that had fallen onto the floor. She sustained a laceration to the right eyebrow and was bleeding. She was transported to a local trauma hospital. A nursing progress note, dated 5/12/25 at 8:33 a.m., indicated Resident 88 returned form the hospital after she sustained right sided mandible fracture and thoracic spine fractures. An IDT progress note, dated 5/12/25 at 12:28 p.m., indicated Resident 88 sustained a fall on 5/11/25 after she was witnessed to attempt to pick up personal items from the dining room floor. Active bleeding was noted at the time of the fall, first aide was provided and after the resident complained of a headache she was sent to the emergency room for further evaluation and treatment. She was diagnosed with a right-side mandible fracture and fracture of the first and third thoracic spine. The IDT determined new interventions to be put in place were: a wheelchair side storage bag for personal items, a reacher to keep with and utilize while in her wheelchair and she was referred to therapy for wheelchair positioning. Her care plan was updated. Resident 88's comprehensive care plan was reviewed. She had a care plan, dated 4/1/24, which indicated she was at risk for falls related to her diagnoses. Interventions for this plan of care included, but were not limited to: therapy to procure reacher for resident's use created on 7/1/24 and reacher for resident to keep with wheelchair and utilize while in wheelchair created 5/12/25. An intervention in all caps, DO NOT LEAVE UNATTENDED IN DINING ROOM, created on 9/20/24 and PLEASE LAY RESIDENT DOWN AFTER MEALS, created 9/20/24. Resident 88's fall care plan also included interventions created on 9/11/24 for wheelchair and bed alarms to be placed. The record lacked documentation of a comprehensive fall risk assessment before the wheelchair and bed alarms were installed. The record lacked documentation that the resident and/or representatives were educated on the use of and/or alternatives before installing the alarms. The record lacked documentation that the resident and/or representative gave informed consent for the use of alarms before installation. 2. On 6/5/25 at 10:25 a.m. Resident 96 was observed as he laid in bed watching TV. There was a fall mat on floor next to the resident's bed, his call light was within reach, and there was a regular mattress on his bedframe. On 6/9/25 at 9:35 a.m. Resident 96's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to, dementia and unspecified psychosis. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 4/14/25 at 7:15 a.m., indicated the resident was found on the floor by his bed. No pain was noted, and the resident only indicated he was ready to get up. An Interdisciplinary Team (IDT) note, dated 4/15/25 at 9:10 p.m., indicated the new fall intervention for Resident 96's fall on 4/14/25 was to put a perimeter mattress (a mattress that features raised foam bolsters along its sides to help prevent Residents from rolling out of bed or accidentally falling) on his bedframe. On 6/9/25 at 1:05 p.m. Resident 96 was observed as he laid in bed with the bed in the lowest position and the floor mat was next to his bed. It was found that there was a regular mattress on his bedframe, no bolsters or perimeter mattress were present. 3. On 6/10/25 at 1:56 p.m. Resident 85's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to, type 2 diabetes, weakness, and repeated falls. A progress note, dated 9/8/24 at 12:13 a.m., indicated Resident 85 was found sitting on the floor next to her bed and wheelchair. An IDT note, dated 9/9/24 at 12:59 p.m., indicated the new fall intervention for Resident 85's fall on 9/8/25 was to educate her on the importance of call light use and not attempting to toilet herself. A progress note, dated 3/4/25 at 12:54 p.m., indicated the writer of the note was going to check Resident 85's blood sugar when they found the resident lying on the floor next to her bed. An IDT note, dated 3/5/25 at 5:28 p.m., indicated the new fall intervention for Resident 85's fall on 3/4/25 was to utilize a bed alarm. On 6/10/25 at 3:40 p.m. Resident 85 was observed as she laid in bed resting with her eyes closed. The door was closed upon entering the room. The resident's call light was found on the floor next to the bed. Licensed Practical Nurse (LPN) 10 who usually worked with Resident 85 came to observe the room. LPN 10 indicated they normally kept her door cracked because the resident liked the door closed, but they never closed it all the way. LPN 10 indicated the resident's call light should have been in bed with the resident within reach. When asked about Resident 85's bed alarm LPN 10 indicated it was a pad that goes on the bed that they could also use on the wheelchair. Upon observation of the bed alarm pad, it was found that the pad was not plugged into the alarm box. LPN plugged the bed pad into the alarm box and indicated it should always be plugged in to work properly. On 6/9/25 at 11:45 a.m., the Administrator provided a copy of current but undated facility policy titled, Assessing Falls and Their Causes. The policy indicated, .Falls are a leading cause of morbidity and mortality among the elderly in nursing homes . falling may be related to underlying clinical or medical conditions, overall functional decline, medication side effects, and/or environmental risk factors . When a resident falls, the following information should be recorded in the resident's medical record . interventions and appropriate interventions taken to prevent future falls (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/9/25 at 11:45 a.m., the Administrator provided a copy of current but undated facility policy titled, Use of Chair [and Bed] Alarms. The policy indicated, .conduct a comprehensive fall risk assessment before initiating [an alarm] . consider alternatives to alarm use before implementation . discuss proposed alarm use with the resident and/or representative to obtain informed consent 3.1-45(a)(1) 3.1-45(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. The facility failed to date medications for 1 of 3 medication carts observed. (100 hall Cart 1 and 2). Findings include: 1. Medication cart 1 on 100-hall was observed. Resident 92 had a bottle of latanoprost (used to treat glaucoma) in the medication cart that should be stored in the refrigerator until it was opened. She had a bottle of ofloxacin eye drops 0.3% (used for eye infections) with no date on it to indicate when it was opened. Resident 79 had a bottle of fluticasone nasal spray (used to treat allergies) 50 mcg in the medication cart with no date on it to indicate when it was opened. 2. Medication cart 2 on 100-hall was observed. Resident 40 had a bottle of Systane balance (used to treat dry eyes) in the medication cart with no date to indicate when it was opened. On 6/11/25 during a conversation with the Director of Nursing (DON), she indicated it was very difficult to keep up with dating of medications. A policy titled, Storage of Medications and Biologicals was provided by the Executive Director (ED) on 6/10/25 at 10:30 a.m. It indicated, .In accordance with State and Federal laws, manufacturer recommendations or supplier recommendations, the facility must store all medications and biological in locked compartments or storage rooms under proper temperature controls, and permit only authorized personnel to have access to the keys 3.1-25(j) 3.1-25(m) 3.1-25(n)