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	05/13/2026

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 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. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when a resident was transferred with only one staff and without a lift which resulted in actual harm of a tibia fracture for 1 of 6 residents reviewed for accidents (Resident 64), and the facility failed to prevent potential for accidents when a resident's medications were left at bedside without a self-administration assessment for 1 of 28 residents observed for environments (Resident 45).Findings include:Findings include: 1. On 5/12/26 at 9:20 a.m., Resident 64 was observed reclined in her bed, her right leg uncovered by the bed sheet so that her knee was observed. The knee was significantly swollen. Resident 64 was unable to indicate what happened. On 5/12/26 at 9:30 a.m., Physical Therapist (PT) 7 entered Resident 64's room and indicated, she needed to put a brace on the resident's knee before she left for an Orthopedic appointment later that day for a fracture she had sustained over the weekend. During an interview on 5/12/26 at 10:41 a.m., the Administrator (ADM) indicated the investigation was still ongoing into how Resident 64 acquired a tibia fracture. He indicated he had interviewed nursing staff and discovered, Resident 64 had been seen up in her wheelchair but without the Hoyer lift (a mechanical device that helps caregivers safely transfer individuals with limited mobility between beds, wheelchairs, or the toilet) pad underneath her per her usual. When the ADM questioned CNA 7, she admitted that she transferred Resident 64 into bed without the Hoyer lift. On 5/12/26 at 11:46 a.m., Resident 64 who had been brought to the front assistive dining room was heard as she called out, OW! Resident 64's right leg was extended outward and rested on a foot pedal. An unidentified Certified Nursing Aide (CNA) indicated as she was positioning Resident 64 to the table her extended leg must have bumped into something. During an interview on 5/12/26 at 12:53 p.m., CNA 8 indicated she worked with Resident 64 on a regular basis. CNA 8 confirmed the resident required a Hoyer lift for all transfers but indicated she had performed transfers of Resident 64 without the Hoyer lift to put her to bed on 5/8/26. During an interview on 5/12/26 at 1:08 p.m. CNA 9 indicated CNA 8 worked a double shift on 5/8/26 and put Resident 64 to bed. CNA 9 indicated she did not witness the transfer, but also confirmed, Resident 64 required a Hoyer lift for all transfers. On 5/12/26 at 9:34 a.m., Resident 64's record was reviewed. She was a long-term care resident who had diagnoses which included, but were not limited to, speech and language deficits following an unspecified cerebrovascular disease (a group of conditions that affect blood flow and the blood (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 0689 Level of Harm - Actual harm Residents Affected - Few	vessels in the brain), vascular dementia (damaged or blocked blood vessels that reduce blood flow and oxygen to the brain causing impaired judgment, difficulty planning, slower thinking, and memory loss), epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden surges of electrical activity in the brain), and Pseudobulbar affect (a neurological condition characterized by sudden, uncontrollable, and inappropriate outbursts of laughing or crying). Resident 64 had a current physician's order, ordered 6/17/25, to use a Hoyer lift for all transfers. She had a comprehensive care plan, dated 2/27/26, which indicated she was dependent on staff for all activities of daily living (ADLs) which included, but were not limited to, bed mobility and transfers. An intervention for her transfer status was initiated 2/27/26 and specified the use of a Hoyer lift for all transfers. Her most recent comprehensive assessment was a quarterly Minimum Data Set (MDS) assessment, dated 3/17/26. The MDS indicated she was severely cognitively impaired and had exhibited no behaviors in the lookback window. A physician note, dated 3/18/26, indicated Resident 64 had .experienced suspected seizure activity on February 19 with tremors, no verbal response, and fixed gaze lasting a few minutes, and similar activity on January 17 with fixed gaze to the left, generalized spastic jerking, rapid respirations, and drooling.Patient has mixed type Alzheimer's and vascular dementia in severe stages with behavioral disturbance and limited verbal communication abilities following CVA [Cerebrovascular Accident, occurs when blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients]. She remains dependent for all ADLs, wheelchair dependent with Hoyer lift for transfers. Nurses' notes, dated 4/15/26 at 11:19 am and 9:42 pm, indicated Resident 64 had seizure activity at 11:10 a.m. and 5 p.m. A nurse's note, dated 4/28/26 at 2:13 p.m., indicated Resident 64 was screaming and cursing at staff, hitting herself with closed fists, and holding on to the Hoyer lift during transfer shaking the lift. A nurse's note, dated 5/1/26 at 10:38 a.m., indicated the resident continued to scream out and was resistive to care, and would often grab the transfer sling and Hoyer during transfers. A Physiatry progress note, dated 5/5/26, indicated Resident 64's chief complaints were mobility and activities of daily living (ADL) deficits due to muscle atrophy (wasting or loss of muscle tissue), debility (a state of physical weakness), poor endurance (ability to sustain prolonged physical effort against fatigue), fall risk, and a history of CVA. The resident was picked up by therapy for rehabilitation due to generalized weakness, debility, poor endurance, and fall risk. The resident was pleasantly confused and only oriented to person. The note indicated, .Current functional status as of 5/1/26: The patient requires max assistance with bed mobility, max assistance with sit-to-stand transfers, and total assistance with chair to bed and bed to chair transfers using a Hoyer lift. She is unable to ambulate. A nursing progress note, dated 5/9/26 at 11:18 a.m., indicated Resident 64 had new and severe swelling and pain in her right knee with limited range of motion. The Nurse Practitioner (NP) was notified and a new order for Tylenol twice a day as needed was given. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note, dated 5/9/26 at 4:09 p.m., indicated Resident 64 continued to have swelling with severe pain to her right knee with movement. Resident screaming during bed mobility specifically when right knee is touched. The Tylenol had been administered but was not effective. The NP was notified and a new order for an x-ray was given. A nursing progress note, dated 5/9/26 at 6:29 p.m., indicated Resident 64's x-ray results were received and showed an acute appearing proximal tibia fracture. Her family declined sending her to the emergency room, so an orthopedic (ortho) appointment was scheduled for 5/12/26. A nursing progress note, dated 5/10/26 at 6:01 a.m., indicated Resident 64 continued to have pain and yelled out with movement of her leg. Tylenol was given. A nursing progress note, dated 5/10/26 at10:37 a.m., indicated nursing staff contacted the on-call NP with concerns about exceeding the recommended dose of Tylenol and requested a repeat x-ray of Resident 64's knee. The NP declined the second x-ray, discontinued the Tylenol orders and gave new orders to give Tramadol every 8 hours as needed for knee pain. A NP progress note dated 5/11/26 at 12:00 a.m. indicated Resident 64 was seen for a follow up to the acute knee pain and swelling. Nursing reported noticing swelling to the patient's right knee on May 9 with pain noted with mobility. The on-call provider was notified, and orders were received for Tylenol 1000 mg twice daily as needed. Later that afternoon, nursing reported that pain to the right knee had worsened with movement, mobility, or touch. Imaging was ordered and completed, showing an acute proximal tibia fracture. The patient's family declined sending the patient to the ER for further evaluation and treatment. The patient was referred to Ortho with orders to elevate the right lower extremity and ice the knee as needed. The patient was made non-weight bearing to the right lower extremity. The patient is non-ambulatory at baseline and requires a Hoyer lift for transfers. Nursing notified the on-call provider again related to pain management, and tramadol 50 mg every 8 hours as needed was ordered. The patient did have seizure activity reported on May 7 while in bed. Staff was present during the seizure activity and did not observe any injury during the seizure activity. The patient has not had any recent falls and is dependent for mobility and transfers. A nursing progress note, dated 5/11/26 at 6:04 a.m., indicated Resident 64 continued to have pain with movement of her leg. Tylenol and ice packs were given. On 5/12/26 at 12:58 p.m., the Administrator provided a copy of current, but undated facility policy titled, Safe Lifting and Movement of Residents. The policy indicated, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents in accordance with resident assessments, manufacturer instructions, and applicable federal and state regulations. Manual lifting of residents shall be eliminated when feasible and replaced with appropriate mechanical or assistive devices. Mechanical lifting devices shall be used for heavy lifting and for lifting and moving residents when manual lifting would place the resident or staff at risk. Failure to follow staffing requirements may result in corrective action. Safe lifting is incorporated into the facility's employee health and safety program, including injury prevention, training, and evaluation. On 5/12/26 at 11:05 a.m., the Administrator provided a copy of current, but undated facility policy titled, Fall Assessment. The policy indicated, Falls are a leading cause of morbidity and mortality among the elderly in nursing homes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. On 5/7/26 at 10:00 a.m., Resident 45 was observed with a cup of medications on his bedside table in his room. There were approximately 11 pills in the medication cup with a glass of water sitting next to the cup of pills. On 5/11/26 at 11:50 a.m., a record review was completed for Resident 45. He had the following diagnoses which included, but were not limited to, dementia (decline in memory and thinking skills severe enough to impair daily life) and cataracts (a clouding of the eye's natural lens that prevents light from clearly reaching the retina, leading to blurry, faded vision, and sensitivity to glare). A self-medication administration assessment was completed on 2/3/26. It indicated that resident was not to administer his medications on his own. On 5/11/26 at 12:05 p.m., during an interview with LPN 6, she indicated Resident 45 could not administer his own medications. A policy titled, Medication Administration, with no date was provided by the Executive Director on 5/12/26 at 1:02 p.m. It indicated, .Medication cannot, under any circumstance, be left at the patient bedside. Licensed staff must witness the ingestion of the prescribed medication by the resident. 410 Indiana Administrative Code (IAC) 16.2-3.1-45.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure vital sign equipment was cleaned between residents (Residents 28 and 83), appropriate infection control techniques were used during blood glucose (sugar) checks, glucometers (measures blood sugar) were cleaned between residents (Residents 125 and 31), and enhanced barrier precautions (EBP) (infection control measures requiring staff to wear gowns and gloves during high-contact resident care to prevent the spread of multidrug-resistant organisms) were followed (Resident 93) during 5 of 35 medication observations. Findings include:1. During an observation, on 5/12/26 at 8:12 a.m., Licensed Practical Nurse (LPN) 5 used a portable vital signs machine to check Resident 28's blood pressure and oxygen saturation with the attached pulse oximeter. LPN 5 did not clean the blood pressure cuff or the pulse oximeter before or after using it. During an observation, on 5/12/26 at 8:23 a.m., LPN 5 used the same portable vital signs machine to check Resident 83's blood pressure and oxygen saturation. LPN 5 did not clean the blood pressure cuff or the pulse oximeter before or after using it. During an interview, on 5/12/26 at 9:58 a.m., the Director of Nursing (DON) indicated vital sign equipment should have been cleaned between each resident. On 5/12/26 at 11:04 a.m., the Administrator provided an undated document titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: The purpose of this procedure is to provide guidelines for disinfection of non-critical resident-care items.General Guidelines.c. Non-critical items are those that come in contact with intact skin but not mucous membranes. (1) Non-critical resident-care items include.blood pressure cuffs.d. Reusable items are cleaned and disinfected or sterilized between residents. 2. During an observation, on 5/12/26 at 11:13 a.m., LPN 6 checked Resident 125's blood glucose. LPN 6 removed a basket containing lancets, a container of glucometer strips, and the glucometer, and took it to Resident 125's room. LPN 6 sat the basket directly on the resident's bedside table with no barrier. With gloved hands, LPN 6 cleaned Resident 125's finger with an alcohol swab, reached into the communal container of glucometer strips, and placed one in the glucometer. LPN 6 completed the blood glucose check, put the container of glucometer strips and the glucometer back in the basket, and returned it to the medication cart. LPN 6 did not clean the glucometer before or after using it. During an observation, on 5/12/26 at 11:18 a.m., LPN 6 checked Resident 31's blood glucose. LPN 6 took the same basket, containing the lancets, a container of glucometer strips, and the glucometer, and entered the resident's room. LPN 6 placed the basket directly on the resident's bedside table and the glucometer on the resident's bed. No barriers were used. With gloved hands, LPN 6 cleaned Resident 31's finger with an alcohol swab, reached into the communal container of glucometer strips, and placed one in the glucometer. LPN 6 completed the blood glucose check, put the container of glucometer strips and the glucometer back in the basket, and returned it to the medication cart. LPN 6 did not clean the glucometer before or after using it. During an interview, on 5/12/26 at 11:20 a.m., LPN 6 indicated she thought the glucometer needed to be cleaned every third resident. On 5/12/26 at 12:56 p.m., the DON provided a list of residents who required blood glucose checks. The document indicated none of the residents had a blood-borne pathogen. During an interview, on 5/12/26 at 2:19 p.m., the DON indicated the glucometer should have been cleaned between each resident. She was not sure if a barrier should have been put down between the surface and the equipment or if it was acceptable for the nurse to use the same gloved hand that touched the resident to obtain the glucometer strip from the communal container of glucometer strips. On 5/12/26 at 3:28 p.m., the Administrator provided an undated document titled, Blood Glucose Monitoring, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy.The licensed nurse performs the blood glucose test safely.4. Clean & Disinfect.c. Wash hands and apply gloves before cleaning the monitor. D. Thoroughly clean the meter. 3. During an observation, on 5/12/26 at 2:15 p.m., LPN 7 administered medication via gastrostomy tube (g-tube) (a tube inserted into the stomach through the abdomen for the administration of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplemental nutrition and medications) to Resident 93. A sign outside Resident 93's room indicated Enhanced Barrier Precautions (EBP) were required during high-contact care. LPN 7 did not wear a gown during the g-tube medication administration. During an interview, on 5/12/26 at 2:15 p.m., LPN 7 indicated she did not think Resident 93 required EBP. During an interview, on 5/12/26 at 2:19 p.m., the DON indicated EBP should have been used with the administration of medications via g-tube. Resident 93's record was reviewed on 5/12/26 at 2:50 p.m. A physician's order, dated 10/21/25, indicated enhanced barrier precautions related to the g-tube. On 5/12/26 at 3:28 p.m., the Administrator provided an undated document titled, Enhanced Barrier Precautions, and indicated it was the policy currently being used by the facility. The policy indicated, .Enhanced barrier precautions.are utilized to prevent the spread of multi-drug resistant organisms.to residents.2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity [as opposed to before entering the room].3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include.g. device care or use.feeding tube. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure documentation of a resident's chosen advanced directive was consistent across his medical record for 1 of 32 residents reviewed for accurate advanced directive documentation. (Resident 59)Findings include:On 12/8/26 at 12:29 p.m. Resident 59's medical record was reviewed. He was a rehab resident whose diagnoses included, but were not limited to, cerebral infarction (stroke) and hemiplegia (paralysis of one side of the body, often due to a stroke). Resident 59 was admitted to the facility on [DATE].Resident 59 had an Out of Hospital (OOH) Do Not Resuscitate (DNR) declaration, dated and signed on 2/20/26, uploaded into his medical record.A banner on Resident 59's medical record home page indicated he had elected to be a full code.Resident 59 had an active order for full code status dated 4/19/26.Resident 59 had an active care plan that indicated he was a DNR with a signed OOH DNR form on file, dated 2/23/26.During an interview on 5/13/26 at 11:10 a.m. the Director of Nursing (DON) indicated she was unaware there were discrepancies related to Resident 59's advanced directive status in his medical record. She indicated she would investigate it and correct any discrepancies immediately.On 5/13/26 at 12:37 p.m. a copy of a current facility policy titled Advanced Directives, dated September 2022 was provided. That policy indicated, .If the Resident Has an Advance Directive.2. The Director of Nursing Services (DNS) or designee notifies the attending physician of advanced directives.so that appropriate orders can be documented in the residents' medical record.3. The residents' wishes are communicated to the residents' direct care staff and physician by placing the advanced directive documents in a prominent, accessible location in the medical record.410 IAC (Indiana Administrative Code) 16.2-3.1-4(f)(4)(A)(ii).410 IAC (Indiana Administrative Code) 16.2-3.1-4(f)(5).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a bed hold notification to residents or resident representatives for 2 of 4 residents reviewed for appropriate discharge process (Residents 114 and 82).Findings include:1. On 5/11/26 at 2:05 p.m., a record review was completed for Resident 114. She had the following diagnoses which included, but were not limited to, congestive heart failure (CHF, a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), diabetes mellitus type 2 (a chronic metabolic disorder where your body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels), and hypertension (high blood pressure). On 4/23/26 at 1:07 a.m., a progress note indicated Resident 114 complained of abdominal pain throughout the shift, rating it an 8 out of 10 on a pain scale. Her abdomen was distended. The physician was notified and an order was noted to send resident to the hospital for further evaluation. The resident's medical record lacked documentation of a bed hold. On 5/12/26 at 1:42 p.m., during an interview with the Director of Nursing (DON), she indicated she could not find any information related to the discharge on [DATE]. 2. On 5/11/26 at 9:23 a.m. Resident 82's medical record was reviewed. She was a long-term care Resident whose diagnoses included but were not limited to type 2 diabetes and chronic kidney disease (long-term, progressive loss of kidney function). A progress note, dated 2/24/26, indicated the facility sent Resident 82 to the hospital due to a critically low blood potassium level. The medical record lacked documentation that a bed hold notification was provided to Resident 82 or a Resident representative. During an interview on 5/13/26 at 10:27 a.m. the Director of Nursing (DON) indicated she was unable to find documentation of a signed bed hold notification for Resident 82's hospitalization on 2/24/26. On 5/13/26 at 12:37 p.m. a copy of a current, undated facility policy titled Bed-Holds and Returns was provided. That policy indicated, .Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. Residents, regardless of payer source, are provided written notice about these policies at least twice:.b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 1 of 23 residents' MDS assessments reviewed (Resident 6). Findings include: Resident 6's record was reviewed on 5/11/26 at 11:50 a.m. Census information indicated the resident was admitted to the facility on [DATE]. An annual MDS assessment, dated 2/6/26, indicated the resident was cognitively intact and had one fall with a major injury. The resident's electronic record lacked documentation the resident had a fall with major injury. During an interview, on 5/11/26 at 1:00 p.m., the Director of Nursing (DON) indicated the annual MDS assessment, dated 2/6/26, was not accurate. The resident had not had a fall with major injury. The facility utilized the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) manual as their policy for MDS assessment accuracy. The CMS MDS RAI Manual Version 3.0, dated October 2025, indicated, .Coding Instructions for J1900.Code 1, one: if the resident had one non-injurious fall since admission/entry or reentry or prior assessment. 410 IAC (Indiana Administrative Code) 16.2-3.1-31(b)(1)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to ensure a Resident's Pre-admission Screening and Resident Review (PASRR) (a federal Medicaid requirement ensuring individuals with serious mental illness or intellectual disabilities are not inappropriately placed in nursing homes) was re-evaluated when there were inaccuracies on the assessment and when a psychiatric diagnosis was added for 2 of 3 residents reviewed for PASRR (Resident 8 and 76).Findings include:1. On 5/12/26 at 1:29 p.m. Resident 8's medical record was reviewed.She was a long-term care resident whose diagnoses included, but were not limited to, unspecified mood disorder, paranoid personality disorder (intense, irrational, and persistent feelings that others intend to harm, deceive, or exploit you), and depression (a common, serious mood disorder that causes persistent sadness, loss of interest, and affects how you feel, think, and behave). Resident 8 had a diagnosis of schizophrenia (a chronic and severe brain disorder that affects how a person interprets reality causing a combination of hallucinations (such as hearing voices), delusions (false beliefs), disorganized thinking, and impaired daily functioning) that was added on 1/12/26 and deleted on 2/10/26, and a diagnosis of bipolar disorder (mental health condition characterized by extreme shifts in mood, energy, and activity levels) that was added on 1/12/16 and resolved on 3/24/26.Resident 8 had a PASRR assessment, dated 3/27/26, uploaded into her medical record. That assessment indicated Resident 8 currently had the following mental health diagnoses, schizophrenia, major depression (serious mood disorder characterized by a persistently low or sad mood, and a severe loss of interest in activities), bipolar disorder, and paranoid disorder.Resident 8's medical record lacked documentation of an active diagnosis of schizophrenia, major depression, or bipolar disorder on the date of the PASRR assessment.During an interview on 5/13/26 at 11:21 a.m. the Executive Director (ED) indicated the Director of Nursing (DON) was initiating a new PASRR assessment for Resident 8 to correct the inaccuracies. He indicated based on number 4 in their policy they should have done a new level 1 due to inaccuracies in the assessment.2. On 5/11/26 at 12:35 p.m. Resident 76's medical record was reviewed.He was a long-term care resident whose diagnoses included, but were not limited to, other specified mental disorders due to known physiological condition added on 3/16/26 and hallucinations (a false sensory perception that feels entirely real but occurs without any external physical stimulus) added on 4/27/26.Resident 76 had a PASRR assessment, dated 2/13/26, uploaded into his medical record. That assessment indicated he did not have any current mental health diagnoses.The record lacked documentation of a new PASRR assessment being completed when new mental health diagnoses were added on 3/16/26 and 4/27/26.During an interview on 5/13/26 at 11:35 a.m. the ED indicated they did not do a new PASRR when the new mental health diagnoses were added. He indicated the DON was initiating a new assessment immediately.On 5/13/26 at 12:37 p.m. a copy of a current, undated facility policy titled, Preadmission Screening and Resident Review (PASRR), was provided. That policy indicated, .4. Changes in Resident Condition: - A Resident Review is required if there is a significant change in status indicating the presence of or change in SMI [Serious Mental Illness], ID [Intellectual Disability], or RC [Related Conditions]. - The facility must notify the state PASRR authority and request a new evaluation if warranted.410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)

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	05/13/2026

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 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. Based on observation, interview, and record review, the facility failed to ensure a resident who sustained a fall and complained of neck pain with swelling was assessed prior to being moved and was moved before emergency medical staff arrived for 1 of 3 residents reviewed for falls, (Resident 7), and failed to follow physician's orders related to congestive heart failure (CHF) (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently, causing fluid to build up in the lungs and body) for 1 of 10 residents reviewed for quality of care (Resident 114).Findings include: 1. On 5/11/26 at 11:30 a.m., Resident 7's record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, chronic kidney disease (a progressive condition where damaged kidneys slowly lose their ability to filter waste and excess fluid from the blood) and hypertension (high blood pressure). A nursing progress note, dated 1/29/26 at 5:36 a.m., indicated, at appropriately 5:06 a.m., the Certified Nursing Aide (CNA) notified the writer that Resident 7 was found sitting on the floor beside his bed. Writer immediately assessed the resident. Resident 7 was found sitting on the floor, with his two hands on the bed, and one leg folded. The resident stated, I rolled out of bed. On assessment Resident 7 complained of pain at the back of his head. There was slight swelling noted to neck. All extremities were movable without pain or discomfort. No bruising or bleeding was observed at the time. With assistance of two CNAs, the resident was safely transferred back in bed. The resident was hypotensive [low blood pressure] with blood pressure of 73/42 and complained of dizziness. Speech was clear, but resident was dizzy. He responded to name, pain, and environment. While vital signs were being taken, resident experienced a seizure lasting approximately 1 minute. After the seizure activity stopped, the resident returned to baseline. Resident was positioned on side to prevent aspiration. The on call Nurse Practitioner (NP) was notified and a verbal order was received to send the resident to the emergency room (ER). Prior to the arrival of the Emergency Medical Services (EMS), Resident 7 had an additional seizure lasting 15 seconds. 911 was called at 5:15 a.m. EMS arrived at 5:20 a.m. Resident was transported to ER via EMS. An interdisciplinary team (IDT) progress note, dated 1/29/26 at 8:36 p.m., indicated, Resident had an unwitnessed fall on 1/29/26 at 5:06 a.m. CNA notified nurse that resident was sitting on the floor. Upon entering the room, the nurse noted that the resident was sitting on the floor with two hands on the bed and a leg folded. Resident stated to the nurse that he rolled out of bed. Nurse assessed resident; at time of assessment, resident [complained of] pain to the back of head. Nurse noted slight swelling to the neck. Resident [blood pressure] - 73/42, but able to move all extremities, AROM [active range of motion] without pain. Nursing staff assisted resident back into bed. On call ordered to send resident to ER for eval and tx d[due to] possible seizure activity. The resident's record lacked documentation of if the resident was moved prior to seizure activity, vital signs, and assessment were completed or after their completion. During an interview on 5/12/26 at 10:31 a.m., Licensed Practical Nurse (LPN) 10 indicated if a resident sustained a fall and complained of neck pain and/or if the assessment revealed neck swelling, the resident should absolutely not be moved. The nurse should try to keep the resident as still as possible until 911 arrived. During an interview on 5/12/26 at 10:33 a.m., Qualified Medication Aide (QMA) 11 indicated she could (continued on next page)

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	155041	A. Building B. Wing	05/13/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not assess a resident, but if she found a resident on the floor she would call for the nurse to immediately assess and try to keep the resident as still as possible. During an interview on 5/12/26 at 1:00 p.m., the Director of Nursing indicated if a resident sustained a fall witnessed or not, and complained of neck pain with noted neck swelling, the nurse should not move that resident until emergency medical professional arrived. The DON indicated it was unclear if the resident was moved before or after the assessment and seizure activity. On 5/12/26 at 11:05 a.m., the Administrator provided a copy of current, but undated facility policy titled, Fall Assessment. The policy indicated, The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Falls are a leading cause of morbidity and mortality among the elderly in nursing homes. If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. 2. On 5/11/26 at 2:05 p.m., a record review was completed for Resident 114. She had the following diagnoses which included but were not limited to, congestive heart failure (CHF) (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently, causing fluid to build up in the lungs and body), and hypertension (high blood pressure). She had an order, dated 3/9/26, to weigh her daily related to CHF, special instructions: notify provider when resident weight is greater than 2 pounds per day or 5 pounds in one week. Resident 114 had a care plan dated 4/9/26. It indicated that resident was at risk for cardiac complications related to hypertension, coronary artery disease (CAD), and CHF. An intervention dated 3/9/26 indicated to weight resident daily. Resident 114's Medication Administration Record (MAR) was reviewed. On 4/16/26 her weight was 132.0 pounds and on 4/17/26 her weight was 137.0 pounds. That was a 5-pound weight gain. The record lacked documentation of notification of the physician. On 4/19/26 her weight was 133.2 and on 4/20/26 her weight was 136.6. That was a 3.4-pound weight gain. The record lacked documentation of notification of the physician. On 5/12/26 at 1:32 p.m., during an interview, the Director of Nursing indicated she could not find the notification of physician and resident was assigned to an outside provider. An undated policy titled, Reporting Weight Changes was provided by the Executive Director (ED) on 5/12/26 at 12:58 p.m. It indicated .Report significant weight loss/weight gain to the nurse supervisor and physician. 410 Indiana Administrative Code (IAC) 16.2-3.1-37.