PRINTED: 03/01/2023

DEPARTMENT	EPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED								
CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPI	LETED		
		155041	B. WING			01/20	/2023		
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD				
NORTH	WEST MANOR HEA	ALTH CARE CENTER		6440 W 34TH ST INDIANAPOLIS, IN 46224					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
F 0000									
Bldg. 00									
		Recertification and State	F 00	000	Preparation and or execution				
	Licensure Survey. This visit included the Investigation of Complaint IN00398309.				this plan of correction does no				
					constitute admission or agree				
					by the provider of the truth of				
	_	3309 - Substantiated. No			facts alleged or conclusions s	set			
	deficiencies related	to the allegations are cited.			forth in the statement of				
		17 10 10 100 2002			deficiencies. The plan of				
	Survey dates: Janua	ary 17, 18, 19 and 20, 2023.			correction is prepared and/or				
	E:1:41 00	00015			executed because it is require	-			
	Facility number: 00 Provider number: 1				the provisions of federal and	state			
	AIM number: 1002				law.				
	Anvi number: 1002	73730							
	Census Bed Type:								
	SNF/NF: 88								
	SNF: 7								
	Total: 95								
	Census Payor Type Medicare: 9	:							
	Medicaid: 66								
	Other: 20								
	Total: 95								
	These deficiencies	reflect State Findings cited in							
	accordance with 41								
	accordance with 41	0 110 10.2 3.1.							
	Quality review com	apleted on January 31, 2023.							
F 0578	483.10(c)(6)(8)(g)	(12)(i)-(v)							
SS=D		Oscntnue Trmnt;FormIte Adv							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance

Bldg. 00

Dir

directive.

TITLE (X6) DATE

Bryce Reagan HFA Administrator 02/16/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041			JILDING	instruction 00	(X3) DATE COMPL 01/20/	ETED	
	PROVIDER OR SUPPLIER	ALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
AAG	§483.10(c)(8) Not should be construresident to receive treatment or mediamedically unneces \$483.10(g)(12) The the requirements at 489, subpart I (Ad (i) These requirements and provide adult residents color refuse medical at the resident's ordirective. (ii) This includes a facility's policies to directives and approvider entities are prother entities to further entities to further entities to further equirements and includes a the requirements of the requirements of the requirements of the time of admissing receive information to the or she has directive, the facility directive information to provide this information. Follow place to provide the requirements and the provide the sinformation. Follow place to provide the receive information.	hing in this paragraph ed as the right of the e the provision of medical cal services deemed essary or inappropriate. The facility must comply with especified in 42 CFR part vance Directives). The ents include provisions to the written information to all the provisions to the provision of the the written description of the to implement advance					
		on, interview, and record	F 0:	578	F-578 SS- D		02/20/2023
	review, the facility:	failed ensure advanced			It is the intention of Northwe	st	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/20/2023 155041 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6440 W 34TH ST NORTHWEST MANOR HEALTH CARE CENTER INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE directives were legally signed and available on the Manor Health Care Center to resident record for 2 of 3 residents reviewed for ensure advance directives are advanced directives (Residents 198 and 202). completed legally and present on a resident's record. Findings include: What corrective action(s) will be accomplished to those 1. On 1/17/23 at 11:03 a.m., Resident 198 was residents found to have been observed and interviewed as she rested in bed affected by the deficient watching television. practice: Advance directives were verified On 1/18/23 at 9:54 a.m., Resident 198's medical by the resident and/or resident record was reviewed. The diagnoses included, but representative for both residents were not limited to chronic kidney disease, identified during the survey. The hypertension (high blood pressure) and facility verified the appropriate hyperlipidemia (high cholesterol). Physician orders, Advance Directive forms and care plans are A physician's order, dated 12/29/22, indicated Do in place according to the Not Resuscitate (DNR). resident's choice. How other resident Resident 198 did not have an advanced directive having the potential to be document in the medical record. Documentation affected by the same deficient was requested. practice will be identified and that corrective action(s) will be On 1/19/23 the Executive Director (ED) provided taken: an out of hospital do not resuscitate order and An audit was completed to ensure declaration form for Resident 198. The form was physician orders, Advance dated 1/19/23 and signed by the resident, 2 Directive forms and care plans witnesses and the physician on 1/19/23. were in place and in compliance. What measures will be 2. On 1/17/23 at 11:29 a.m., Resident 202 was put in place or what systematic observed and interviewed as he was seated in a changes will be made to wheelchair in his room watching television. The ensure that the deficient resident was somewhat confused. He did not practice does not recur: know how long he had been at the facility and The facility will provide education kept asking what he was supposed to do next. to staff completing Advance Directive forms to ensure On 1/17/23 at 1:55 p.m., Resident 202's medical compliance with proper execution record was reviewed. The diagnoses included, but of required forms. Social Service were not limited to, urinary tract infection, sepsis Director or designee will complete (infection in the blood stream), encephalopathy an admission audit to ensure the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/20/2023 155041 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6440 W 34TH ST NORTHWEST MANOR HEALTH CARE CENTER INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (deterioration of the brain), kidney failure and resident's right to formulate an malignant neoplasm of the prostate (cancer). advance directive was upheld. The audit will ensure if the resident Resident 202 had an out of hospital do not chooses to formulate an advance resuscitate declaration order, dated 1/5/23. The directive. it is executed and document indicated it had been obtained over the documented in accordance with telephone with Resident 202's court appointed federal and state regulations. guardian. The document had a place for 2 witness Director of Nursing or designee will signatures, but only had one witness signature. complete an audit to ensure The physician signature was dated 1/5/23. appropriate Physician's orders are obtained and care plans are On 1/20/23 at 10:16 a.m., during an interview, the developed to uphold the resident's Director of Nursing (DON) indicated Residents choices. Whenever a resident 198 and 202 should have had all DNR documents wishes to implement new advance and care plans in the medical record. She did not directives or change advance know if an out of hospital do not resuscitate order directives already in place, an taken over the phone required 2 witness advance directive audit will be signatures, she would have to check the policy. completed by the interdisciplinary clinical team to ensure advance On 1/20/23 at 9:00 a.m., the ED provided a current, directives are documented in undated policy, titled "Do not Resuscitate accordance with federal and state Orders." This policy indicated "...The facility will regulations and facility policy. The document in the resident's record whether or not audit process will begin 2/17/2023. he or she has an executed DNR. When the How the corrective resident has executed a DNR, a copy of that action(s) will be monitored to document will be made part of the resident's ensure the deficient practice record....." will not recur, i.e., what quality assurance program will be put 3.1-4(d)in place: 3.1-4(1)(4) The admission advance directive 3.1-38(f)audit will be ongoing by the Social Service Director and interdisciplinary clinical team. The audit results will be reviewed during the clinical portion of the department head meeting. Any documentation identifying residents with new advance directives or a change in advance directives will be identified in the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/01/2023 FORM APPROVED OMB NO. 0938-039

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 01/20/2023		
	PROVIDER OR SUPPLIEF	ALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
E 0644	492.20/-\			facility clinical meeting. Then a audit will be completed to ensithe advance directive form of choice was completed legally, physician's orders were obtain and choices were added to the resident's care plan. The week audit log, maintained by the S Service Director or designee, be reviewed with the Administ weekly for one month, then two month for 2 months and then monthly for 3 months. The week audit log will be presented in monthly QAPI meetings with a expected compliance of 100%. Social Service Director or designee will complete a montadvance directive audit involving least 10% of the facility reside and results will be reported in monthly QAPI meetings for 6 months with an expected compliance of 100%. The exprompliance rate established be the QAPI team is 100%. If the threshold falls below the target the monitoring will continue unpattern of compliance is established with 3 consecutive months of 100%. This monitor process will begin 2/20/2023. 5. By what date the systemic changes will be completed: 2/20/2023	ned, e kly ocial will trator vice a ekly an c, thly ing at onts ect by et, otil a		
F 0641 SS=D	483.20(g) Accuracy of Asses	ssments					

FORM CMS-2567(02-99) Previous Versions Obsolete

§483.20(g) Accuracy of Assessments.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155041	B. W	ING		01/20/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	_
NAME OF I	PROVIDER OR SUPPLIEF	R			V 34TH ST		
NORTHV	WEST MANOR HEA	ALTH CARE CENTER			NAPOLIS, IN 46224		
	1				1		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION The assessment must accurately reflect the			TAG	DEFICIENCI	DATE	_
		must accurately reflect the					
	resident's status.			C 4.1		02/20/2022	
	Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately		F 00	541	F 641	02/20/2023	
					SS-D	-4	
					It is the intention of Northwe		
	coded for 3 of 19 residents reviewed for MDS				Manor Health Care Center to		
	accuracy (Residents 59, 45 and 79).				complete an assessment to	4	
	Eindings in sludes				accurately reflect the reside	nt	
	Findings include:				status.	(a)	
	1 Pasidant 50's ma	edical record was reviewed on			What corrective action will be accomplished to those		
		. His diagnoses included, but			residents found to have bee		
	were not limited to retention of urine, urinary tract					11	
	infection, cerebral infarction (stroke), vision				affected by the deficient		
	deficit, and sepsis (a serious condition resulting				practice: A MDS correction was made	and	
		of harmful microorganism in the			submitted upon finding the	anu	
	blood or other tissu	_			identified inaccuracies on eac	.h	
	blood of other tissu	ic).			resident identified during the	-11	
	Resident 50 had a N	Notice of PASRR level II			survey.		
		7/2020. The PASSR indicated			Survey.		
		ed a level II due to diagnoses of			2. How other resident		
	_	exictly disorder, depressive			having the potential to be		
	disorder, and histor	-			affected by the same deficie	nt	
		y e1 4.2 e1.01 4.0 4.5 e.			practice will be identified an		
	His comprehensive	MDS, dated 7/20/22, indicated			that corrective action(s) will		
	_	y considered by the State level			taken:		
		to have a serious mental illness			A MDS audit was completed to	with	
	•	disability or a related condition.			an MDS auditor to ensure MD		
		-			accuracy for sections related		
	2. Resident 45's me	edical record was reviewed on			the inaccuracies found. No ot		
	1/19/23 at 10:04 a.ı	m. His diagnoses included but			inaccuracies were found.		
		cerebral infarction (stroke),					
		nutrition, major depressive			3. What measures will be		
	disorder, heart dise	ase, vascular dementia, spinal			put in place or what systema	atic	
		ens when the space inside the			changes will be made to		
		oo small, placing pressure on			ensure that the deficient		
		nerves) and flexion deformity			practice does not recur:		
		nip cannot be straightened			MDS auditor or designee will	proof	
	actively or passivel	y.			MDS assessment sections du	·	
					their routine visit. Substantial		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041 NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER A. BUILDING 00 COMPLETED 01/20/2023 STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224	Ň
155041 B. WING O1/20/2023 STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST	ìN
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST	'n
NAME OF PROVIDER OR SUPPLIER 6440 W 34TH ST	iΝ
	νN
INDICTITIVES I WANDE DEALTH CARE CENTER INDIANAPOLIS, IN 40224	iΝ
	Ν
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)	N
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
Resident 45 was receiving hospice services compliance is defined as 95%	
through a local hospice company. He was accurate for 3 months. The audit	
admitted to hospice on 1/22/22. His MDS, dated process was started on 1/31/2023.	
11/2/22, did not indicate that he was receiving 4. How the corrective	
hospices services. His care plan, dated 1/3/22, action(s) will be monitored to	
indicated he was receiving hospice services ensure the deficient practice	
related to severe protein calorie malnutrition and will not recur, i.e., what quality	
vascular dementia. assurance program will be put	
in place:	
During an interview with the MDS Coordinator, MDS coordinator or designee will	
on 1//19/23 at 10:24 a.m., she indicated she was present results of MDS audits in	
not aware that Resident 59 had a level II. She the Quality Assurance	
indicated she would provide a corrected MDS for Performance Improvement	
Resident 59 to reflect he had a level II. committee meetings monthly. The	
expected accuracy rate will be	
During the interview regarding the lack of coding 100% for 3 months or 3 MDS	
for a fall for Resident 47 and lack of coding auditor visits. The acceptable	
hospice for Resident 45; the MDS Coordinator compliance rate established by	
indicated "It is what it is, I guess." The MDS the QAPI team is 95%. If the 95%	
Coordinator indicated she would follow up if she	
had any additional documentation. 3. During an monitoring will end after 3 months	
interview, on 1/17/23 at 10:59 a.m., Licensed of substantial compliance. If the	
Practical Nurse (LPN) 4 indicated Resident 79's threshold falls below the target, threshold falls below the target,	
Foley catheter was out, and had been out for a monitoring will continue until	
while. substantial compliance is	
On 1/18/23 at 9:08 a.m., during an observation of establish for 3 consecutive months or 3 MDS auditor visits.	
Resident 79 while up in her Broda chair, no Foley catheter bag was observed. An unidentified staff 5. By what date the systemic changes will be	
member who was on the medication cart, indicated completed:	
her Foley catheter was out. Solid control of the incident of cart, indicated Completed: 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2023 2/20/2020 2/20/2023 2/20/2020 2/20/2020 2/20/2020 2/20/2020 2/20/2020 2/20/2020 2/20/20	
101cy Catheter was out. 2/20/2025	
During a conversation, on 1/18/23 at 3:00 p.m., the	
MDS Coordinator (MDSC) indicated the most	
recent MDS (Minimum Data Set) sent indicated	
Resident 70 had an indwelling catheter with	
treatment. She reviewed Resident 79's chart and	
indicated the indwelling Foley catheter was	
removed on 11/1/22, and it should not have been	
on the 1/6/23 MDS.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY TPLETED 20/2023			
	PROVIDER OR SUPPLIER	LTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	(DON) indicated the was to have all physoriginal was saved if the yellow copy was then all orders go to On 1/19/23 at 12:41 Section Z from the state the accompany reflects resident assersidentAs a bas funds. I further undefederal funds and conditioned on the atthis information' On 1/19/23 at 12:41 page from, "CMS's review indicated, "Functioned that facil	p.m., the Director of Nursing e process used by the facility sician's orders reviewed, the for the physician to sign, and is to update the care plans and in MDS for them to do updates. p.m., the MDSC provided MDS. It indicated, "I certifying information accurately essment information for this is for payment from federal erstand that payment of such portional participation in the health care programs is accuracy and truthfulness of p.m., the MDSC provided a RAI Version 2.0 Manual." A federal requirements ities use an RAI that has been te. The assessment system						
		ensive, accurate, standardized, ment of each long-term care						
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implemer §483.21(b) Compr §483.21(b)(1) The implement a comp care plan for each the resident rights and §483.10(c)(3) objectives and tim	nt Comprehensive Care Plan rehensive Care Plans facility must develop and prehensive person-centered resident, consistent with set forth at §483.10(c)(2), that includes measurable reframes to meet a , nursing, and mental and						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/20/2023				ETED			
		ROVIDER OR SUPPLIEF	LTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE	
		psychosocial need comprehensive as attain or maintain practicable physicipsychosocial well-§483.24, §483.25 (ii) Any services the required under §4 but are not provide exercise of rights the right to refuse (6). (iii) Any specialized rehabilitative service provide as a result recommendations the findings of the its rationale in the (iv)In consultation resident's represe (A) The resident's desired outcomes (B) The resident's future discharge. If whether the resident's future discharge are plan, as appropriate entities (C) Discharge plan care plan, as appropriate requirements at this section. §483.21(b)(3) The	ds that are identified in the seessment. The are plan must describe the at are to be furnished to the resident's highest al, mental, and being as required under or §483.40; and nat would otherwise be 83.24, §483.25 or §483.40 and due to the resident's under §483.10, including treatment under §483.10(c) and services or specialized ides the nursing facility will to f PASARR. If a facility disagrees with PASARR, it must indicate resident's medical record. with the resident and the notative(s)-goals for admission and the notative of the seessed and any referrals gencies and/or other is, for this purpose. The in the comprehensive copriate, in accordance with set forth in paragraph (c) of the services provided or acility, as outlined by the are plan, must-						

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLET	TED
		155041	B. WI	NG		01/20/20	023
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ 34TH ST		
NORTHV	MEST MANOR HEA	ALTH CARE CENTER			APOLIS, IN 46224		
NORTHV	VEST WANOK HEA	ALTH CARE CENTER		INDIAN	AFOLIS, IN 40224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on observation, interview, and record		F 06	656	F 656	(02/20/2023
	review, the facility failed to ensure comprhensive				SS-E		
	care plans were initiated and implement for 6 of 19				It is the intention of Northwe	st	
		for comprehensive care			Manor Health Care Center to		
	planning (Residents 1, 46, 45, 198, 202, and 5).				ensure comprehensive care		
					plans are initiated and		
	Findings include:				implemented in a timely		
					manner.		
		lical record was reviewed on			(1) What corrective action(s)	
	_	She was admitted on 9/21/22.			will be accomplished to thos		
	_	ided, but were not limited to			residents found to have been	n	
		nur, chronic kidney disease,			affected by the deficient		
		isorder, chronic heart failure,			practice:		
	hypothyroidism, and protein-calorie malnutrition.				The Facility completed a revie		
					the comprehensive care plan		
		um Data Set (MDS), dated,			each of the residents identified		
		he received extensive			with deficient care plans. Care		
		mobility. Her side rail			plans were updated and amer		
		0/21/22, indicated she used her			to ensure compliance with the		
		oler (the rail is used to promote			current plan of care.		
	independence with	bed mobility).			(2) How other resident hav	-	
					the potential to be affected b	-	
	~	ion on 1/18/23 at 10:25 a.m.,			the same deficient practice v	vill	
		erved lying on her right side in			be identified and that		
		losed. She had a half side rail			corrective action(s) will be		
	on both sides of her	r bed.			taken:		
					The facility will complete a rev		
	_	ion on 1/19/23 at 9:10 a.m.,			of the comprehensive care pla		
		erved lying on her right side			for each resident in the facility		
	I	d. She had a half side on both			(3) What measures will be	put	
	sides of her bed.				in place or what systematic		
	B 11 . 11 . 1				changes will be made to		
	•	an lacked a problem, goal, and			ensure that the deficient		
	interventions to add	dress the use of side rails.			practice does not recur:		
	2 D 11 +461	1. 1. 1			Director of Nursing or designe		
		edical record was reviewed on			review physician orders in the		
		m. She was admitted on 12/9/22.			clinical department meeting. (
	_	ided, but were not limited to			plans are reviewed and amen	ded	
		r in which nerve cell activity in			in the meeting as needed		
	the brain is disturbed	ed, causing seizures),			according to physician orders	or I	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/20/2023 155041 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6440 W 34TH ST NORTHWEST MANOR HEALTH CARE CENTER INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE pneumonia (an infection of the lungs), acute care issues identified during the embolism of deep veins of the lower extremities, clinical review. Comprehensive anorexia (an eating disorder), autistic disorder (a care plans will be updated weekly broad range of conditions characterized by according to the MDS challenges with social skills, repetitive behaviors, assessments by Unit Managers, speech and non-verbal communication), other Nursing management, or contracture of muscle, multiple sites (permanent designee. The list of completed tightening of the muscles, tendon, skin and care plan updates will be returned nearby tissues that causes the joints to shorten to the Administrator weekly. and become very stiff) and pressure ulcer of sacral (4) How the corrective region. action(s) will be monitored to ensure the deficient practice Resident 46's MDS, dated 10/2/22, indicated she will not recur, i.e., what quality was dependent on two persons with bed mobility. assurance program will be put Her side rail assessment, dated 12/13/22, indicated in place: she used her side rails as an enabler. The weekly care plan update lists will be reviewed weekly by the During an observation on 1/16/23 at 9:30 a.m., Administrator or designee for a Resident 46 was observed lying in bed, facing her period of three months. A window. She was holding a stuffed animal. She comprehensive care plan audit will has a low air loss mattress. She had her eyes be completed monthly on ten opened, but she was non-verbal. She had one percent of the facility residents for half side rails on both sides of her bed. a period of three months. The audit process will start on 2/20/23. During an observation on 1/19/23 at 10:16 a.m., The compliance rate is expected Resident 46 was non-verbal. She was observed to be 100%. The acceptable lying on her left side, holding a small stuffed compliance rate, established by animal in her right hand. She was able to make the QAPI team is 90%. If the 90% eye contact. She had one half side rails on both -100% threshold is met, the sides of her bed. monitoring will end after 3 months of substantial compliance. If the Resident 46's care plan lacked a problem, goal, and threshold falls below the target, interventions to address the use of side rails. the monitoring will continue without a stop date. A pattern of 3. Resident 45's medical record was reviewed on compliance will be established 1/19/23 at 10:04 a.m. He was admitted on 5/9/21. with 3 consecutive months of 90% His diagnoses included, but were not limited to -100%. cerebral infarction (stroke), protein-calorie

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malnutrition, major depressive disorder, heart

disease, vascular dementia, spinal stenosis (this

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By what date the systemic

changes will be completed:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/20/2023	
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440 V	ADDRESS, CITY, STATE, ZIP COD V 34TH ST JAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROP	BE COMPLETION
	too small, placing p	pace inside the backbone is ressure on the spinal cord and deformity of the left hip.		2/20/2023	
	dependent on two p side rail assessment	2/22 indicated he was ersons for bed mobility. His , dated 11/15/22, indicated he grab bars as an enabler.			
	lying in bed with hi attached to his grab bed. He had an unp	served on 1/17/23 at 9:38 a.m., s head pushing against a pad bar on the right side of his badded grab bar on the left was unable to reposition			
	He was sitting up in was leaning into the	served on 1/19/23 at 2:15 p.m. his reclining chair. His head e padded frame of the chair. eposition in the chair.			
		olan lacked a problem, goal, and lress the use of grab bars.			
	the Owner, Admini the DON indicated could use their rails indicated the reside	on 1/20/23 at 9:40 a.m., with strator and Director of Nursing, that Residents 1, 45 and 46 as an enabler. The DON nt's medical record lacked a the side rails on resident's			
	DON indicated she half rails changed to demonstrated that I her bed rail. The D Resident 45 could I hand to indicate he	on 1/20/23 at 11:05 a.m., the would have Resident 46's one of a grab bar. The DON desident 46 could hold onto ON demonstrated that hold a blanket and shake her could hold his grab bars, at to grasp with his hand4. On			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/20/2023		
	PROVIDER OR SUPPLIEF	ALTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE C	(X5) OMPLETION DATE
		n., Resident 198 was observed she rested in bed watching				
	record was reviewe					
	A physician's order DNR, do not resusc	, dated 12/29/22, indicated itate.				
	Resident 198 did not have an advanced directive care plan.					
	of hospital do not re	cutive Director provided an out esuscitate order and r Resident 198. The form was				
	observed and interv wheel chair in his re- resident was somew know how long he l	29 a.m., Resident 202 was iewed as he was seated in a boom watching television. The what confused. He did not had been at the facility and was suppose to do next.				
	record was reviewe were not limited to, (infection in the blo (deterioration of the	p.m., Resident 202's medical d. The diagnoses included, but urinary tract infection, sepsis and stream), encephalopathy brain), kidney failure and a of the prostate (cancer).				
		out of hospital do not on order, dated 1/5/23.				
	Resident 202 did no care plan.	ot have an advanced directive				

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	PROVIDER OR SUPPLIER	LTH CARE CENTER	64	40 W	DDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	On 1/20/23 at 10:16 Director of Nursing 198 and 202 should and care plans in the at 2:16 p.m., Reside was admitted on 5/5 Her diagnoses inclu chronic respiratory bring in enough oxy dioxide), and cerebr Her physician's orde limited to, administ shift, dated 7/22/22 weekly, dated 7/24/ Resident 5 did not h 1/19/23, the facility administer oxygen, protocol and provid During an interview Director of Nursing physician's order co and it was mentione The orders were dis assessment would b facility added more orders with the DOI orders as PRN (as n management staff w	da.m., during an interview, the (DON) indicated Residents have had all DNR documents a medical record. 6. On 1/19/23 ant 5's record was reviewed. She 5/22. ded, but were not limited to, failure (failure of the lungs to agen and eliminate carbon ral infarction (stroke). ers included, but were not er 4 L oxygen via NC every and change oxygen tubing 22. have an oxygen care plan. On provided one, it indicated to change the oxygen tubing per					
F 0657 SS=E Bldg. 00	- , , ,						

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155041	B. W.	ING		01/20	/2023
NAME OF L			•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEI	K		6440 W	/ 34TH ST		
NORTH	WEST MANOR HEA	ALTH CARE CENTER		INDIAN	IAPOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DET CEENCT?		DATE
	must be-	oin 7 days after completion					
	of the comprehen	nin 7 days after completion					
		n interdisciplinary team, that					
	includes but is no						
	(A) The attending						
		urse with responsibility for					
	the resident.	War respondibility for					
		with responsibility for the					
	resident.						
	(D) A member of food and nutrition services						
	staff.						
	(E) To the extent practicable, the						
	participation of the resident and the resident's						
	representative(s).	An explanation must be					
		dent's medical record if the					
	1 .	e resident and their resident					
	1	determined not practicable					
		ent of the resident's care					
	plan.						
	. ,	iate staff or professionals in					
	-	ermined by the resident's					
	1	ested by the resident.					
	(iii)Reviewed and						
		eam after each assessment, comprehensive and					
	quarterly review a	-					
	1	on, interview, and record	F 00	557	F 657		02/20/2023
		failed to ensure comprehensive		JJ 1	SS= E		02/20/2023
		rised and/or updated for 4 of 19			It is the intention of Northwe	est	
	•	for comprehensive care			Manor Health Care Center to		
		s 23, 45, 59 and 83).			ensure comprehensive care		
					plans are revised and update		
	Finding include:				in a timely manner.		
					1. What corrective action	ı(s)	
	_	edical record was reviewed on			will be accomplished to thos	se	
	1/19/23 at 2:10 p.m	1.			residents found to have bee	n	
					affected by the deficient		
	_	ided, but were not limited to,			practice:		
	hyperlipidemia (hig	gh cholesterol), hypothyroidism			The Facility completed a revie	ew of	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		A. BUILDING <u>00</u> COMP		(X3) DATE COMPI 01/20	LETED		
	PROVIDER OR SUPPLIE	R ALTH CARE CENTER	<u> </u>	6440 W	ADDRESS, CITY, STATE, ZIP COD 7 34TH ST APOLIS, IN 46224	•	
(X4) ID	SUMMARV	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		ctivity of the thyroid gland),			the comprehensive care plan	for	
		ety, anemia, depression, and			each of the residents identifie		
		the deep veins of the upper			with deficient care plans. Care	9	
	extremity.				plans were updated and ame		
					to ensure compliance with the		
	Resident 23 had a	care plan, dated 5/21/21,			current plan of care.		
		e UTI (Urinary Tract Infection).			· ·		
	Her medical record	l lacked evidence of a UTI.			2. How other resident		
					having the potential to be		
	Her care plan, date	d 5/21/21, indicated she			affected by the same deficie	nt	
	received two diuret	tics. Her physician orders lack			practice will be identified an		
orders for diuretic medications. Her Minimum				that corrective action(s) will	be		
	Data Set (MDS), dated 10/19/22, indicated she did				taken:		
	not receive any diuretics during the assessment				The facility will complete a rev	/iew	
	period.				of the comprehensive care pla	ans	
					for each resident in the facility		
	Her care plan, date	d 5/21/21, indicated she had			_		
	difficulty with slee	p due to insomnia. An			3. What measures will be)	
	intervention includ	ed to monitor the effectiveness			put in place or what systema	atic	
	of medication thera	py. Her medication orders			changes will be made to		
	lacked an order for	a medication to treat insomnia.			ensure that the deficient		
	Her MDS dated 1/1	19/22 did not indicate she			practice does not recur:		
	received medicatio	n to treat insomnia during the			Physician orders are reviewed	d in	
	assessment period.				the clinical department meetir	ng.	
					Care plans are reviewed and		
	_	d 5/21/21, indicated she			amended in the meeting as		
		gulant medication. Her			needed according to physician		
		acked an order for an			orders or care issues identifie	d	
	_	cation. Her MDS dated			during the clinical review.		
		dicate she received an			Whiteboard has been initiated	l to	
	anticoagulant durir	ng the assessment period.			monitor changes in physician		
					orders, facility events, or new		
		edical record was reviewed on			specialized services or equipr		
		m. His diagnoses included but			to guide the creation or revision		
		cerebral infarction (stroke),			a resident care plan. Whitebo		
	_	nutrition, major depressive			will be updated during the clin	iical	
		ase, vascular dementia, spinal			department meeting and as		
	`	ens when the space inside the			needed. Comprehensive care		
		all, placing pressure on the			plans will be updated weekly		
	I spinal cord and ner	ves), and flexion deformity of			according to the MDS		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/20/2023 155041 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6440 W 34TH ST NORTHWEST MANOR HEALTH CARE CENTER INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the left hip (the hip cannot be straightened assessments by Unit Managers, actively or passively). other Nursing management, or designee. The list of completed His care plan, dated 4/22/21, indicated he had a care plan updates will be returned pressure ulcer to his sacrum. The medical record to the Administrator weekly. lacked orders or documentation to treat or address How the corrective a pressure ulcer. His MDS, dated 11/2/22, action(s) will be monitored to indicated he does not have a pressure ulcer. ensure the deficient practice will not recur, i.e., what quality His care plan, dated 4/22/21, indicated he used an assurance program will be put antidepressant medication. His current physician in place: orders lacked an antidepressant medication. His The weekly care plan update lists MDS, dated 11/2/22, did not indicate he received will be reviewed weekly by the an antidepressant during the assessment period. Administrator or designee for a period of three months. A 3. Resident 59's medical record was reviewed on comprehensive care plan audit will 1/19/23 at 8:00 a.m. His diagnoses included, but be completed monthly on ten were not limited to retention of urine, urinary tract percent of the facility residents for infection, cerebral infarction (stroke), vision a period of three months. The deficit, and sepsis (a serious condition resulting audit process will start on 2/20/23. from the presence of harmful microorganism in the The compliance rate is expected blood or other tissue). to be 100%. The acceptable compliance rate, established by Resident 59's indwelling catheter was the QAPI team is 90%. If the 90% discontinued on 1/9/23. His care plan indicated he -100% threshold is met, the had a urinary catheter, indwelling, related to monitoring will end after 3 months urinary retention. of substantial compliance. If the threshold falls below the target, During an interview with the Owner, the monitoring will continue Administrator and Director of Nursing (DON) on without a stop date. A pattern of 1/20/23 at 9:20 a.m., the DON indicated the UM compliance will be established (Unit Managers) are responsible for initiating and with 3 consecutive months of 90% revising residents care plans with changes. The -100% DON indicated herself and the Transitional Care Nurse will revise care plans also. The DON By what date the indicated "they" do a great job at initiating care systemic changes will be plans, but need to do better at updating them. 4. completed: On 1/17/23 at 9:56 a.m., Resident 83 was initially 2/20/23 observed. He laid in bed on his back, his eyes were open, and he answered questions

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/20/2023
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	with three layers, a third top blanket. H and liked the weigh pressure reliving bo	as observed to be covered sheet, a fleece blanket, and a e indicated he was often cold t of the blankets. He had ots to both of his feet but at his toes were in direct ight of the blankets.			
	He remained in bed blankets. His toes re weight of the blank pressure reliving bo	p.m., Resident 83 was observed. , covered with layers of emained in contact with the ets as they stuck out past his ots. He indicated his feet did mes his toes tingled.			
	He remained in bed	a.m., Resident 83 was observed. , covered with layers of cross the top of his toes.			
	83's room. She indicated a lot of blankets over when she removed were uncovered, the aredness at the corresproximately the sb. a red blister-like big toe, approximate	ca.m., CNA 15 entered Resident cated Resident 83 liked to keep or him because he got cold and his blankets so that his feet of following was observed: mer of his left big toe, lize of dime. The area to the knuckle of his left bely the size of a pencil eraser. Ster area to the knuckle of his			
	Wound Nurse (WN a greater risk for prohistory of wounds a reviewed his compr time and indicated ton his coccyx shoul wound had been her	on 1/19/23 at 12:03 p.m., the indicated Resident 83 was at essure ulcers since he had a nd was on hospice. She ehensive care plans at that he care plan for an open area d not still be active as that alled months ago. She not appear to be any revisions			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/20/2023	
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440 V	ADDRESS, CITY, STATE, ZIP COD V 34TH ST JAPOLIS, IN 46224	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	LD BE COMPLETION COMPLETION
PREFIX TAG	in place to address to additional blankets from developing as During an interview WN indicated she was to Resident 83's toe observe them at this blankets back, the Ware three new area one on his right big assessment, she indicated she would to the areas, possibly that would go higher sheets from touching aids not to tuck the On 1/18/23 at 2:25 record was reviewed. He was a long-term hospice care and dianot limited to, Parking the place of the property of the property of the was a long-term hospice care and dianot limited to, Parking the place of	the Resident's preference for and how to prevent new areas a result of the blankets. 7 on 1/19/23 at 12:30 p.m., the was not aware of any new areas a new and a available to go at time. When she pulled his WN indicated it appeared there as, two to his left big toe, and toe. Upon her initial icated all three areas were were not pressure ulcers at untreated could turn into ppeared the areas had weight of the sheets and from ked in, under his feet which sure to the areas. The WN I get new orders for skin prep y order new pressure boots or over his toes to prevent the g, and she would educate the sheets too tight. p.m., Resident 83's medical d. care resident who received agnoses which included, but inson's disease. care plans were reviewed.	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	LD BE COMPLETION
	for being at risk of	which was initiated on 3/18/22 developing pressure ulcers nce, impaired mobility and			

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE CO A. BUILDING B. WING		
	PROVIDER OR SUPPLIER	ALTH CARE CENTER	6440 V	ADDRESS, CITY, STATE, ZIP COD V 34TH ST NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the Resident's prefe additional blankets. On 1/20/23 at 9:15 of current, but unda "Updating Care Pla actual or potential	a.m., the ADM provided a copy ted facility policy titled, ns." The policy indicated, " l problems may be addressed ontinually reviewed and			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Ulcer §483.25(b) Skin Ir §483.25(b)(1) Pre Based on the com a resident, the fac (i) A resident rece professional stand pressure ulcers ar pressure ulcers ur condition demons unavoidable; and (ii) A resident with necessary treatme with professional s promote healing, p new ulcers from d Based on observation	ressure ulcers. Inprehensive assessment of cility must ensure that- ives care, consistent with dards of practice, to prevent and does not develop alless the individual's clinical trates that they were In pressure ulcers receives ent and services, consistent estandards of practice, to prevent infection and prevent	F 0686	It is the intention of Northwe	02/20/2020
	for the developmen resident, (Resident layers of blankets w	t of pressure ulcers for a 83) who preferred to use thick which caused weight and for 1 of 2 residents reviewed for		identify the potential for development of pressure ulc with appropriate intervention to prevent pressure ulcers. 1. What corrective action will be accomplished to thos residents found to have been	eers ns (s)

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155041	B. W	ING		01/20/	2023
				STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	t.		6440 W	/ 34TH ST		
NORTH	WEST MANOR HEA	LTH CARE CENTER		INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	N.	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	INAIL	DATE
					affected by the deficient		
	On 1/17/23 at 9:56	a.m., Resident 83 was initially			practice:		
	observed. He laid in	bed on his back, his eyes			A skin assessment was		
	were open, and he a	nswered questions			completed on the resident		
	appropriately. He w	as observed to be covered			identified during the survey	by the	
	with three layers, a	sheet, a fleece blanket, and a			facility wound nurse on 1/19)/2023.	
	third top blanket. H	e indicated he was often cold			Physician orders were obtai	ned for	
	and liked the weigh	t of the blankets. He had			treatment to the areas ident	ified at	
	pressure reliving bo	oots to both of his feet but			risk for skin breakdown.		
	wore no socks so th	at his toes were in direct			Interventions were impleme	nted to	
	contact with the we	ight of the blankets.			reduce pressure or friction to	o the	
					areas caused by blankets. ()n	
	On 1/18/23 at 2:06	p.m., Resident 83 was observed.			1/20/23, a skin assessment	was	
	He remained in bed	, covered with layers of			completed on the identified		
	blankets. His toes re	emained in contact with the			resident, the areas of conce	ern	
	weight of the blank	ets as they stuck out past his			were no longer present and	did not	
	pressure reliving bo	oots. He indicated his feet did			develop into pressure areas	; <u>.</u>	
	not hurt, but someti	mes his toes tingled.					
					2. How other resident		
		a.m., Resident 83 was observed.			having the potential to be		
		, covered with layers of			affected by the same defic	ient	
	blankets that laid ac	cross the top of his toes.			practice will be identified a	ınd	
					that corrective action(s) wi	ill be	
	_	y, on 1/19/23 at 11:37 a.m., Unit			taken:		
		ndicated Resident 83 was on			A skin assessment was		
	hospice and needed	extra close attention in all			performed on each resident	in the	
	_	because he as very fragile. He			facility to identify any area o	f	
	had a history of pre	ssure ulcers, so the staff took			concerns.		
	care to keep his pre	ssure boots on at all times, and					
		ned and repositioned at least			3. What measures will I		
	-	t this time, Certified Nursing			put in place or what syster	natic	
	` ′	approached the nurse's			changes will be made to		
		she was going to Resident			ensure that the deficient		
	83's room to reposit	tion him before lunch.			practice does not recur:		
					Education will be provided to	0	
	On 1/19/23 at 11:42	2 a.m., CNA 15 entered Resident			clinical staff on identifying a	nd	
	83's room. She indi	cated, Resident 83 liked to keep			reporting areas of potential		
	a lot of blankets over	er him because he got cold and			pressure ulcers. Educated v	vill be	

when she removed his blankets so that his feet

were uncovered, the following was observed:

provided on the utilization of the

INTERACT Stop and Watch

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/20/2023 155041 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6440 W 34TH ST NORTHWEST MANOR HEALTH CARE CENTER INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE a. redness at the corner of his left big toe, monitoring tool to report areas of approximately the size of dime. concern for potential development b. a red blister-like area to the knuckle of his left of pressure areas and implement big toe, approximately the size of a pencil eraser. interventions to prevent pressure c. a smaller, red blister area to the knuckle of his ulcers. Director of Nursing or right big toe. designee will collect completed Stop and Watch forms during daily During an interview on 1/19/23 at 12:03 p.m., the clinical rounds. Clinical rounds Wound Nurse (WN) indicated Resident 83 was at performed by the clinical a greater risk for pressure ulcers since he had a Interdisciplinary team will be history of wounds and was on hospice. She ongoing. Weekly skin reviewed his comprehensive care plans at that assessments completed by time and indicated the care plan for an open area nurses will be ongoing. on his coccyx should not still be active as that How the corrective wound had been healed months ago. She action(s) will be monitored to indicated there did not appear to be any revisions ensure the deficient practice in place to address the Resident's preference for will not recur, i.e., what quality additional blankets and how to prevent new areas assurance program will be put from developing as a result of the blankets. in place: Director of Nursing or designee will During an interview on 1/19/23 at 12:30 p.m., the monitor the utilization of the WN indicated she was not aware of any new areas INTERACT Stop and Watch tool to Resident 83's toes and was available to go to ensure it is used to identify observe them at this time. When she pulled his potential development of pressure blankets back, the WN indicated it appeared there ulcers and implement preventative were three new areas, two to his left big toe, and interventions. The Director of one on his right big toe. Upon her initial Nursing or designee will complete assessment, she indicated all three areas were an audit weekly for one month, blanchable so they were not pressure ulcers at twice a month for 2 months then that time, but if left untreated could turn into monthly for three months. The pressure ulcers. It appeared the areas had expected compliance rate of developed from the weight of the sheets and from utilizing the INTERACT Stop and the sheets being tucked in, under his feet which Watch tool and implementing pulled and put pressure to the areas. The WN interventions for pressure ulcer indicated she would get new orders for skin prep prevention will be 100%. The audit to the areas, possibly order new pressure boots process will start on 2/20/23. The that would go higher over his toes to prevent the compliance rate is expected to be sheets from touching, and she would educate the 100%. The acceptable aids not to tuck the sheets too tight. compliance rate, established by the QAPI team is 90-100%. If the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155041	B. W				/2023
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					34TH ST		
NORTHV	VEST MANOR HEA	ALTH CARE CENTER		INDIAN.	APOLIS, IN 46224		
(X4) ID	(4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
IAG		p.m., Resident 83's medical	+	IAG	throubold follo bolow the torse	4	DATE
		-			threshold falls below the targe		
	record was reviewe	ed.			the monitoring will continue un	itii a	
					pattern of compliance is		
	_	n care resident who received			established for 3 consecutive		
	1 -	iagnoses which included, but			months of 90-100% compliant	e	
	not limited to, Park	kinson's disease.			rate.		
					By what date the		
	A nursing progress	note dated 1/19/23 at 4:17			systemic changes will be		
	p.m., indicated, "no	oted slightly red area to left			completed:		
	l ~	neasures 0.5 cm (centimeters) x			2/20/2023		
	_	d is blanchable. Denies pain or					
		ssessment. Resident noted to					
		ets on bed per preference as					
		ld. MD (Medical Doctor)					
		nurse made aware of new area.					
	1	ed and noted for skin prep to					
	_	every shift and to not tuck					
		r bed and check placement and					
		oot cradle placed at foot of bed					
	to keep blankets of	f feet"					
		ssessment report dated 1/19/23					
	indicated new redn	less to left great toe, and some					
	pain with wound tr	reatment noted by facial					
	grimacing.						
	His comprehensive	e care plans were reviewed.					
	He had a care plan,	, initiated 7/31/22, for an open					
	_	which had not been revised to					
	indicate the area w						
	He had a care plan	which was initiated on 3/18/22					
		developing pressure ulcers					
		ence, impaired mobility and					
	· · · · · · · · · · · · · · · · · · ·	ad not been revised to address					
	_	erences for his use of					
	additional blankets						
	On 1/20/23 at 9:15	a.m., the Administrator					

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Facility ID: 000015

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	DF CORRECTION IDENTIFICATION NUMBER 155041	A. BUILDING B. WING	00	COMPLETED 01/20/2023
	ROVIDER OR SUPPLIER /EST MANOR HEALTH CARE CENTER	6440 W	DDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	provided a copy of current, but undated, facility policy titled, "Treatment/Services to Prevent/Heal Pressure Ulcers." The policy indicated, "It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centers, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable interventions will be implemented in the resident's plan of care to prevent pressure sore development when the resident has no areas of concern" On 1/20/23 at 9:15 a.m., the Administrator provided a copy of current, but undated facility policy titled, "Updating Care Plans." The policy indicated, "actual or potential problems may be addressed care plans will be continually reviewed and revised as needed" 3.1-40(a)(2)			
F 0688 SS=E Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and			
	§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and			

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/20/2023	
	OF PROVIDER OR SUPPLIER		6440 V	ADDRESS, CITY, STATE, ZIP COD V 34TH ST VAPOLIS, IN 46224		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	services to increa prevent further de §483.25(c)(3) A re receives appropria assistance to mai with the maximum unless a reduction demonstrably una		TAG F 0688	DEFICIENCY)	DATE 02/20/2023	
	review, the facility motion for 4 of 4 re in range of motion and 46). Findings include 1. Resident 23's me 1/19/23 at 2:10 p.m were not limited to, cholesterol), hypotl activity of the thyro anxiety, anemia, de (blood clot) of the cextremity. Resident 23's Minimassessment, dated 1 required extensive a complete her person brushing teeth, shaw washing/drying fac	failed to provide range of esidents reviewed for limitations of joints (Residents 23, 1, 45, and record was reviewed on a. Her diagnoses included, but hyperlipidemia (high hyroidism (abnormally low oid gland), osteoarthritis, epression, and acute embolism deep veins of the upper mum Data Set (MDS) 0/19/22, indicated she assistance of 1 person to nal hygiene (combing hair, wing, applying makeup, e and hands). The MDS was not receiving restorative	F 0688	It is the intention of Northwest Manor Health Care Center to ensure range of motion service are provided. 1. What corrective action will be accomplished to those residents found to have been affected by the deficient practice: Range of motion program documentation was added to a documentation for each reside identified in the survey. Nursing caregiver education was proving for the completion and documentation of range of motion services each day. 2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will taken:	es (s) ie n daily ent ig ided ition	
	assistance with all a due to weakness an indicated to refer th	plan indicated she required activities of daily living (ADLs) d debility. An active goal are resident to occupational ADL retraining, dated 5/21/21.		Range of motion documentation was added to resident's plan of care and daily documentation. Nursing caregiver education was provided for the completion ar	of .vas	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/20/2023	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					/ 34TH ST		
NORTHV	VEST MANOR HEA	LTH CARE CENTER		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					documentation of range of m	otion	
	· ·	p.m., Resident 23 was observed			services each day.		
		n a chair. She indicated she					
	-	ng her hair. She had arthritis in			3. What measures will b		
		ulders making it difficult for			put in place or what system	atic	
		r, but she pushed through and			changes will be made to		
		dependently. Resident 23			ensure that the deficient		
		erapy, but since they stopped			practice does not recur:		
		not had anyone help her with			Interventions for range of mo		
	range of motion of	her upper arms and shoulders.			services will be implemented	upon	
	A. 5. 11. 12.				admission to the facility. The		
		dical record was reviewed on			interventions will be automat	ically	
1/19/23 at 11:59 a.m. Her diagnoses included, but				implemented for all new			
		epilepsy (a disorder in which			admissions to the facility. EN		
	-	n the brain is disturbed,			components will be changed	to	
		neumonia (an infection of the		implement range of motion			
		ism (blood clot) of deep veins		services for each resident			
		ities, anorexia (an eating			admitted or readmitted to the		
	· ·	isorder (a broad range of			facility. A medical records au		
		rized by challenges with social			will be completed upon admi		
	-	naviors, speech and non-verbal			to verify interventions have b	een	
		ontracture of muscle, multiple			implemented by the EMR		
		htening of the muscles,			program. Range of motion	::II b a	
		arby tissues that causes the			documentation monitoring w		
		d become very stiff), and			added to nursing manageme		
	medication orders v	sore) of sacral region. Her			daily documentation monitor	ng tor	
	medication orders v	vere reviewed.			ADL care.		
	Resident 16's MDS	, dated 11/24/22, indicated that			4. How the confective	to	
		endent on staff to provide			action(s) will be monitored ensure the deficient practic		
		MDS indicated that she was			will not recur, i.e., what qua		
		ative nursing and she was not			assurance program will be	-	
	receiving therapy se	_			in place:	put	
	l receiving merapy se	71 11000.			The medical records audit w	:11	
	Resident 46's care r	olan, dated 3/21/22, indicated			occur ongoing as part of the	11	
	-	n in comfort/pain related to			admission audit process. Nu	rsina	
		ad a care plan indicating she			management will complete a	-	
		for all ADL's (bed mobility,			documentation audit weekly		
	-	and eating) related to			month, then twice monthly fo		
	_	ed contractures and			months and then monthly for		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2)		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155041	B. W	NG		01/20/	2023
				CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
NODTUN	VECT MANOR LIEA	LTIL CADE CENTED			34TH ST		
NORTHV	VEST MANOR HEA	LTH CARE CENTER		INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDENCE N. AN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	G DEFICIENCY)		DATE
	dependent for all ca	ire.			months. Audit results will be		
	1				accumulated and reported in t	he	
	During an observati	ion on 1/16/23 at 9:30 a.m.,			facility QAPI meeting monthly.		
	_	served lying in bed, facing her			The audit process will start on		
		nolding a stuffed animal. She			2/20/23. The compliance rate	ie	
		nattress. She had her eyes			expected to be 100%. The		
	opened, but she was				acceptable compliance rate,		
	opened, out she was	, non voicui.			established by the QAPI team	ie	
	During an observati	ion on 1/19/23 at 10:16 a.m.,			90-100%. If the threshold falls		
	•	n-verbal. She was observed			below the target, the monitoring		
		e, holding a small stuffed			will continue until a pattern of	9	
		hand. She was able to make			compliance is established for 3	2	
	eye contact.	nand. She was able to make			consecutive months of 90- 100		
	eye contact.					770	
	2 Danidana 11 d	ical record was reviewed on			compliance rate.		
					5. By what date the		
		Her diagnoses included, but			systemic changes will be		
		fracture of right femur, chronic			completed:		
		or depressive disorder, chronic			2/20/2023		
		nyroidism, and protein-calorie					
	malnutrition.						
	D 11 . 11 MDG	1 . 1 10/0/00 : 1: . 1 1					
	· ·	dated, 10/2/22, indicated she					
		assistance with her ADLs. Her					
		was not receiving a restorative					
	nursing program.						
	_	d 9/22/22, indicated she					
	_	for all ADLs bed mobility,					
		and eating related to visual					
	impairment and chr	onic pain.					
		ion on 1/18/23 at 10:25 a.m.,					
		erved lying on her right side in					
	bed with her eyes c	losed.					
	_	ion on 1/19/23 at 9:10 a.m.,					
		erved lying on her right side					
	with her eyes closed	d.					
	4. Resident 45's me	dical record was reviewed on					

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Facility ID: 000015

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	IT OF DEFICIENCIES OF CORRECTION			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/20/2023
	PROVIDER OR SUPPLIER VEST MANOR HEA	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD V 34TH ST JAPOLIS, IN 46224	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
IAG	1/19/23 at 10:04 a.r were not limited to protein-calorie malidisorder, heart disease stenosis (this happe backbone is too small spinal cord and nervithe left hip. His MDS, dated 11 dependent of staff the MDS indicated her nursing program. His care plan dated assistance with all a toileting and eating (cerebral vascular a weakness and imparate weakn	n. His diagnoses included but cerebral infarction (stroke), nutrition, major depressive ase, vascular dementia, spinal ans when the space inside the all, placing pressure on the zes), and flexion deformity of 2/2/22, indicated he was a complete his ADLs. The vas not receiving a restorative 10/19/20 indicated he required ADLs, bed mobility, transfers, related to dementia, CVA accident (stroke) with left sided ired mobility. Served on 1/17/23 at 9:38 a.m., as head pushing against a pad bar. He was unable to a bed. Served on 1/19/23 at 2:15 p.m. a his reclining chair. His head a padded frame of the chair. position in the chair.	IAG		DATE

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIF A. BUILDII B. WING	PLE CONSTRUCTION NG <u>00</u>	(X3) DATE SURVEY COMPLETED 01/20/2023
	PROVIDER OR SUPPLIER	LTH CARE CENTER	64	REET ADDRESS, CITY, STATE, ZIP COD 40 W 34TH ST DIANAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE
F 0695 SS=E Bldg. 00	copy of current, but "Increase/Prevent E The policy indicates facility to ensure it care and services th accordance with the for care and profess that will meet each psychosocial needs. 3.1-47(a)(1) 483.25(i) Respiratory/Trach Suctioning § 483.25(i) Respir tracheostomy care The facility must e needs respiratory tracheostomy care is provided such o professional stand comprehensive pe the residents' goa 483.65 of this sub Based on observatio review, the facility respiratory durable stored according to dated correctly, and according to facility reviewed for respira 5, 60, 26 and 29). Findings include:	atory care, including and tracheal suctioning, ensure that a resident who care, including and tracheal suctioning, eare, consistent with lards of practice, the erson-centered care plan, is and preferences, and part. In interview, and record failed to ensure resident medical equipment (DME) was policy, oxygen tubing was oxygen was humidified to ensure quipment use (Resident was attory equipment use (Resident	F 0695	F 695 SS= E It in the intention of Northwe Manor Health Care Center to provide respiratory services and equipment with professional standards of practice. 1. What corrective action will be accomplished to the residents found to have been serviced.	n(s)
	1. On 1/1//23 at 11:	:38 a.m., Resident 5 was		affected by the deficient	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2P8511

Facility ID: 000015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
15		155041	B. WING		01/20/2023	
			CTREE	TADDRESS CITY STATE ZIR COD		
NAME OF PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP COD		
NORTHWEST MANOR HEALTH GARE SENTER			W 34TH ST			
NORTHWEST MANOR HEALTH CARE CENTER			INDIA	NAPOLIS, IN 46224		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	observed in bed wit	th a nasal cannula (NC), eyes		practice:		
	closed. Her oxygen	was set at 4 liters (L), it was		The deficiencies identified for	the	
	not humidified. Her	r oxygen tubing was dated		delivery of oxygen and oxygen		
	12/29/22.			equipment were corrected at		
				time of discovery for each res	sident	
	On 1/18/23 at 9:27	a.m., Resident 5 was observed		identified.		
	in bed with a NC, e	yes closed. Her oxygen was set				
	at 4 liters (L), it wa	s not humidified. Her oxygen		2. How other resident		
	tubing was dated 12	2/29/22.		having the potential to be		
				affected by the same deficie	ent	
	On 1/18/23 at 2:20	p.m., Resident 5 was observed		practice will be identified an	d	
	in bed with a NC, e	yes closed. Her oxygen was set		that corrective action(s) will	be	
	at 4 liters (L), it wa	s not humidified. Her oxygen		taken:		
	tubing was dated 12/29/22.			Nursing management comple	eted	
				an audit of all oxygen and oxy	/gen	
	On 1/19/23 at 2:16	p.m., Resident 5's record was		equipment to ensure oxygen	was	
	reviewed. She was	admitted on		being delivered appropriately	and	
	5/5/22. Her diagnos	ses included, but were not		oxygen equipment was dated	and	
	limited to, chronic	respiratory failure (failure of the		stored appropriately. Any		
	lungs to bring in en	ough oxygen and eliminate		problems identified were corr	ected	
	carbon dioxide), an	d cerebral infarction (stroke).		immediately.		
	Her physician's ord	ers included, but were not		3. What measures will be	•	
	limited to, administ	ter 4 L oxygen via NC every		put in place or what system	atic	
	shift, dated 7/22/22	, and change oxygen tubing		changes will be made to		
	weekly, dated 7/24/	/22.		ensure that the deficient		
				practice does not recur:		
	Resident 5 did not l	have an oxygen care plan. On		Consistent staff members will	be	
	1/19/23, the facility	provided one, it indicated to		assigned to complete weekly		
	change oxygen tubi	ing per protocol and provide		rounds to change oxygen		
	humidification.			equipment. Director of Nursin	g or	
				designee will provide a weekl	у	
	2. On 1/17/23 at 11	:21 a.m., Resident 60's		report of residents utilizing ox	ygen	
	unbagged NC was	observed rolled up and laid on		or respiratory equipment and	place	
		oncentrator. He was in his		it in an Oxygen binder. The		
	room utilizing a por	rtable canister for oxygen.		Oxygen binder will be used b	y the	
				assigned staff members while	•	
	On 1/18/23 at 2:16	p.m., Resident 60's unbagged		issuing or changing out		
	NC was observed re	olled up and laid on top of his		equipment. The worksheets in	n the	
oxygen concentrator. He was in his room utilizing		1	Oxygen binder will be used d			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/20/2023 155041 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6440 W 34TH ST NORTHWEST MANOR HEALTH CARE CENTER INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE a portable canister for oxygen. weekly rounds to ensure oxygen equipment is changed and dated On 1/19/23 at 12:07 p.m., his record was reviewed. according to facility policies. His diagnoses included, but were not limited to, Resident education on oxygen chronic respiratory failure and chronic cough, equipment storage will be provided for residents that independently His physician orders included, but were not remove nasal cannulas when limited to, oxygen 2 L via nasal cannula, dated changing from devices that provide 12/23/22, and change oxygen tubing and oxygen, (ex. concentrator to humidifier weekly, dated 12/26/22. portable tank). His oxygen care plan, dated 12/25/22, indicated he How the corrective was at risk for respiratory complications and action(s) will be monitored to administer oxygen therapy as ordered. ensure the deficient practice will not recur, i.e., what quality 3. In 1/18/23 at 2:30 p.m., Resident 26's NC was assurance program will be put observed unbagged and undated. hanging on the in place: oxygen concentrator. The Director of nursing or designee will audit the Oxygen On 1/19/23 at 11:02 a.m., Resident 26's record was binder weekly to ensure proper reviewed. Her diagnoses included, but were not completion of the weekly rounds. limited to, chronic respiratory failure and diabetes The Director of Nursing or mellitus. designee will perform rounds weekly to verify oxygen and Her physician orders included, but were not supplies are provided according to limited to, administer 2 L oxygen via NC, dated facility policy. An audit to ensure 12/28/20, and change oxygen tubing weekly, dated the completion of the Oxygen 6/23/22. binder and rounds will be completed weekly for one month, Her oxygen care plan, dated 2/5/21, indicated she twice a month for 2 months and received oxygen therapy due to respiratory failure monthly for 3 months. The audit and to administer oxygen therapy as ordered and process will begin 2/22/2023. The change tubing per protocol. compliance rate is expected to be 100%. The acceptable During an interview, on 1/18/23 at 2:33 p.m., Unit compliance rate, established by Manager (UM) 9 indicated NC and oxygen tubing the QAPI team is 90-100%. If the should have been changed weekly and dated, NC threshold falls below the target when not in use should have been bagged, and if during the last three months of a resident was over 2 L of oxygen, then it should monitoring, the monitoring will have been humidified. continue until a pattern of

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED			
155041		B. W	B. WING 01/20/2023						
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF F	PROVIDER OR SUPPLIEF	₹							
NORTHWEST MANOR HEALTH CARE CENTER				6440 W 34TH ST INDIANAPOLIS, IN 46224					
NORTHV	VEOT WANDEN 11EA	ALTH OAKL OLNIER		וואטואוו	AI OLIO, IN 40224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
					compliance is established for				
		p.m., UM 9 was observed			three consecutive months of				
		g bags for Residents 26 and 60			90-100% compliance rate.				
		Licensed Practical Nurse							
		ved dating tubing for Resident's			5. By what date the				
		lating a humidifier bottle for			systemic changes will be				
	Resident 5.				completed:				
					2/20/2023				
		p.m., LPN 4 was observed to							
		concentrator for one that							
	would humidify the	e oxygen for Resident 5.							
	On 1/19/22 at 1.49	p.m., the Director of Nurses							
		e nurses should have checked							
		and changed and dated it as							
		should have been aware, if a							
		of oxygen, the oxygen should ed. 4. On 1/18/23 at 10:45 a.m.,							
		on and interview, Resident 29							
	_								
	was in his room wearing oxygen per nasal cann (tube). The tubing and humidifier bottle, which								
	1 ' '	concentrator, were not dated.							
	was on the oxygen	concentrator, were not dated.							
	On 1/18/23 at 2:22	p.m., Resident 29 was observed							
		e of his bed. He wore oxygen							
		connected to a concentrator							
	1 ~	n. He indicated sometimes they							
		but the last time they changed							
	it it had not been m								
	it it had not occir marked.								
	On 1/18/23 at 2:29 p.m., the medical record for								
	Resident 29 was reviewed. The diagnoses								
	included, but were not limited to, chronic								
	respiratory failure, COPD (chronic obstructive								
		diabetes and obstructive							
	sleep apnea.								
	A physician order,	dated 6/23/22, indicated 5 liters							
		l cannula. change oxygen							
	tubing and humidif								

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/01/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		, ,	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/20/	ETED		
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Licensed Practical I indicated oxygen tu should have had a d they were changed.	5 p.m., during an interview, Nurse (LPN) 9, Unit Manager, bing and humidifier bottles late marked on them when She did not know when g or humidifier bottle was						
	On 1/19/23 at 12:05 p.m., the Executive Director (ED) provided a current, undated policy, titled "Departmental (Respiratory Therapy)- Prevention of Infection." This policy indicated "The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staffDistilled water used in respiratory therapy must be dated and initialed when opened, and discarded after 14 days or as neededMark bottle with date and initials upon opening and discard after 14 days, or as neededChange the oxygen cannulae and tubing every seven (7) days, or as neededKeep oxygen cannulae and tubing used PRN [as needed] in a plastic bag when not in use"							
F 0757 SS=E Bldg. 00	Drugs §483.45(d) Unnec Each resident's dr from unnecessary drug is any drug w	excessive dose (including						
	§483.45(d)(2) For	excessive duration; or						

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Event ID:

2P8511

Facility ID: 000015

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 C		COMPL	COMPLETED	
		155041			01/20	/2023		
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER								
NORTHWEST MANOR HEALTH CARE CENTER				6440 W 34TH ST INDIANAPOLIS, IN 46224				
NORTHWEST MANOR HEALTH CARE CENTER				INDIAN				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE	
	§483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.							
			E 0'	757	It is the intention of Northwe	ct	02/20/2023	
	failed to ensure each had a diagnosis increviewed for medic	It is the intention of Northwest Manor Health Care Center to ensure each resident medication order diagnosis included for 7 of 19 residents wed for medication orders with diagnoses dent 1, 16, 23, 37, 45, 46, and 59). F 0757 It is the intention of Northwest Manor Health Care Center to ensure each resident is free from unnecessary drugs. 1. What corrective action(s) will be accomplished to those residents found to have been		(s) e	02/20/2023			
	Findings include:				affected by the deficient practice:			
	1/19/23 at 2:10 p.m Her diagnoses incluhyperlipidemia (hig (abnormally low ac	edical record was reviewed on She was admitted on 5/20/21. Ided, but were not limited to, the cholesterol), hypothyroidism tivity of the thyroid gland), tety, anemia, depression, and		Diagnoses found in the resident's health record were added to the appropriate medication orders for each of the residents identified with medication orders without a diagnosis indicated.		ne for d		
	osteoarthritis, anxiety, anemia, depression, and acute embolism (blood clot) of the deep veins of the upper extremity.				2. How other resident			
					having the potential to be			
	Her medication ord	Her medication orders were reviewed.			affected by the same deficient practice will be identified and that corrective action(s) will	t		
		mg (used to treat depression)			taken:			
	lacked an indication				The facility completed and aud			
		(used as a vitamin supplement)			for all residents to identify other	er		
	lacked an indication				medication orders without a			
	c. Her acetaminopl	nen 325mg (used to treat pain)			diagnosis indicated in the			

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
155041		B. WING 01/20/2023					
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF PROVIDER OR SUPPLIER					/ 34TH ST		
NORTHWEST MANOR HEALTH CARE CENTER				INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	two tablets two times daily lacked an indication				medication order. Any other		
	for use.				medication orders found without		
	_	CL 5mg (used to treat anxiety)		diagnosis indicating its use were		ere	
	lacked an indication				corrected.		
	1	X-STR captab (used as a					
		stomach) lacked an indication			3. What measures will be		
	for use.				put in place or what systema	atic	
	0 D 11 (11				changes will be made to		
		dical record was reviewed on			ensure that the deficient		
	1/9/23 at 2:49 p.m.	She was admitted on 9/21/22.			practice does not recur:	raaa	
	Han dia anggas in alu	ided, but were not limited to			Education was provided to nu		
	_				on ensuring a proper diagnosi	l l	
	fracture of right femur, chronic kidney disease,				provided in a medication orde		
major depressive disorder, chronic heart failure, hypothyroidism, and protein-calorie malnutrition.				Physician orders are collected from the nursing units and brown			
	hypothyroidishi, and protein-calorie manidultion.				to the clinical department	bugiit	
	Her medication orders were reviewed.				meetings. The Director of Nur	eina	
	The medication ord	ers were reviewed.			or designee will review the	31119	
	a. Her levothyroxir	ne 25mcg (used to treat			physician medication orders in	n the	
	1	cked an indication for use.			clinical department meeting to		
		nen 500mg (used to treat pain)			ensure an indication is provide		
	lacked an indication				the written order and EHR sys		
		besylate (used to treat high			,		
	•	ked an indication for use.			4. How the corrective		
		g (used to prevent heart			action(s) will be monitored to	0	
	attacks) lacked an in	ndication for use.			ensure the deficient practice		
	e. Her latanoprost (0.005% eye drops (used to			will not recur, i.e., what qual	ity	
	treat glaucoma) lacl	ked an indication for use.			assurance program will be p	ut	
	f. Her dorzolamide	e 2% eye drops (used to treat			in place:		
		n indication for use.			The Director of Nursing or		
	g. Her stimulant laxative plus (used to treat constipation) lacked an indication for use.				designee will audit medication	l l	
					orders for diagnosis or indicat		
					using a EHR report. The Direc	l l	
		dical record was reviewed on			of nursing or designee will aud	dit	
	1/19/23 at 11:59 a.r	m. She was admitted on 12/9/22.			the report to verify each		
					medication has a diagnosis or		
	_	ided, but were not limited to			indication weekly for one mon		
		in which nerve cell activity in			then twice a month for 2 mont		
		d, causing seizures),			then monthly for 3 months. Th	ne	
pneumonia (an infection of the lungs), acute				audit will begin 2/17/23. The			

ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		COMPLETED					
155041		B. WIN	G		01/20				
		100011	D	_		01/20	72020		
NAME OF I	DROVIDER OR STIDDLIEF	0		STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER				6440 W 34TH ST					
NORTHV	VEST MANOR HEA	ALTH CARE CENTER		INDIAN	APOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)		
PREFIX				REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION		
TAG		NCY MUST BE PRECEDED BY FULL	r		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE			
IAU		R LSC IDENTIFYING INFORMATION		TAG			DATE		
	`	lot) of deep veins of the lower			compliance rate is expected to	o be			
		ia (an eating disorder), autistic			100%. The acceptable				
	disorder (a broad ra	_			compliance rate, established t	-			
	-	allenges with social skills,			the QAPI team is 90-100%. If				
	_	s, speech and non-verbal			threshold falls below the targe				
		ontracture of muscle, multiple			the monitoring will continue ur	ntil a			
		ghtening of the muscles,			pattern of compliance is				
	tendon, skin and ne	earby tissues that causes the			established for 3 consecutive				
	joints to shorten and	d become very stiff) and			months of 90%-100% complia	nce			
	pressure ulcer (bed	sore) of sacral region. Her			rate.				
	medication orders v	were reviewed.							
					5. By what date the				
	a. Her valproic aci	d 250mg (used to treat seizures)			systemic changes will be				
	lacked an indication				completed:				
	b. Her lacosamide	250mg (used to treat seizures)			2/20/2023				
	lacked an indication				_,,				
		Tylenol 120mg (used to treat							
		ed an indication for use.							
		00mg (used to treat shakiness)							
	lacked an indication								
		n (used as a vitamin							
		I an indication for use.							
	spasms) lacked an i	Img (used to treat muscle							
	, ,	g (used as a blood thinner, to							
	ireat blood clots) la	cked an indication for use.							
	4 Dagid 451	adical manand strong area; d - are							
		edical record was reviewed on							
	1/19/23 at 10:04 a.i	m. He was admitted on 5/9/21.							
	His diameter is 1	adad but was not limited to							
	_	ided, but were not limited to							
		(stroke), protein-calorie							
	_	depressive disorder, heart							
	i i	ementia, spinal stenosis (this							
		space inside the backbone is							
		pressure on the spinal cord and							
	nerves) and flexion	deformity of the left hip.							
	His medication ord	ers were reviewed.					1		

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Event ID:

2P8511

Facility ID: 000015

If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER 155041	A. BUILDING B. WING	00 00	COMP	LETED 0/2023
	ROVIDER OR SUPPLIER VEST MANOR HEA	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COI / 34TH ST IAPOLIS, IN 46224)	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	high blood pressure	sium 100mg (used to treat) lacked an indication for use. lical record was reviewed on				
	1/19/23 at 8:00 a.m. His diagnoses include retention of urine, usinfarction (stroke), versious condition researched.	He was admitted on 1/10/23. ded, but were not limited to rinary tract infection, cerebral vision deficit, and sepsis (a sulting from the presence of ism in the blood or other				
	cholesterol) lacked ab. His mirtazapine use c. His olanzepiine disorders) lacked and. His tamsulosin (problems) lacked an e. His lactulose 10g constipation) lacked f. His aspirin 81m attacks) lacked an irg. His azathioprine natural immunity) lab. His metoprolol streat high blood presuse. i. His tradjenta 5m lacked an indication j. His venlafaxine lacked an indication depression) lacked ak. His vitamin B-1 supplement) lacked Resident 16's record	80mg (used to treat high an indication for use. 30mg lacked an indication for use. 5mg (used to treat psychiatric indication for use. 0.4mg (used to treat urine flow indication for use. gm/15ml (used to treat an indication for use. g (used to prevent heart adication for use. (used to lower the body's acked an indication for use. (used to lower the body's acked an indication for use. (used to lower the body's acked an indication for use. (used to treat diabetes) for use. (HCL 262.5mg (used to treat un indication for use. 100mg (used as a vitamin an indication for use. 6. (uses reviewed on 1/19/23 at				
	i. His tradjenta 5m lacked an indication j. His venlafaxine l depression) lacked a k. His vitamin B-1 supplement) lacked Resident 16's record	for use. HCL 262.5mg (used to treat an indication for use. 100mg (used as a vitamin an indication for use.6.				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041		UILDING	nstruction 00	(X3) DATE COMPL 01/20	LETED
	PROVIDER OR SUPPLIEI	R ALTH CARE CENTER	•	6440 W	DDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CTION SHOULD BE COMPLET	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	His diagnoses inclu	ided, but were not limited to,					
	epilepsy (seizure di	sorder), coronary heart					
	disease, and diabetes mellitus (blood sugar						
	disorder).						
	His Medication Ad was reviewed.	ministration Record (MAR)					
	a. His fluticasone (treats allergies) 50 mcg spray order had no physician's indication for use.						
	b. His laxative stimulant (treats constipation) had						
	no physician's indication for use. c. His Levemir FlexTouch injection (treats diabetes) had no physician's indication for use. d. His pantoprazole sodium (treats heartburn) 40						
	mg had no physician's indication for use.						
	_	onate (supplement) 324 mg had					
	no physician's indic						
		reduce the risk of blood clots)					
		ician's indication for use.					
		ER (extended release) (treats					
	high blood pressure indication for use.	e) 25 mg had no physician's					
	h. His levothyroxin	e (treats low thyroid function)					
		nysician's indication for use.					
	,	treats high cholesterol) 40 mg					
	had no physician's						
		reats symptoms of enlarged					
	prostate) 0.4 mg ha	d no physician's indication for					
	use.						
	_	(treats epilepsy) 150 mg had no					
	physician's indicati						
		ssists with sleep) 1 mg had no					
	physician's indicati						
		ex Pen (treats diabetes) had no					
	physician's indicati						
	_	(treats epilepsy) 100 mg had no					
	physician's indicati						
	physician's indicati	en (treats pain)500 mg had no					
		on for use. eats bronchospasms) via					
	P. The arouteror (tre	ais orononospasms) via	ı				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155041	B. Wl	ING		01/20/	2023
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			6440 W	34TH ST		
NORTHV	VEST MANOR HEA	LTH CARE CENTER		INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		ysician's indication for use. (treats seizures) 750 mg had					
	no physician's indic	· · · · · · · · · · · · · · · · · · ·					
		ex Pen (treats diabetes) 10 units					
		physician's indication for use.					
	1	ats pain) 50 mg had no					
	physician's indication						
		d thinner) 2.5 mg had no					
	physician's indication	on for use. 7. On 1/18/23 at 2:39					
	l -	cord for Resident 37 was					
		ssion date was listed as					
	7/16/21.						
	7F1 1' ' 1	1.11.7					
	_	ded but were not limited to, , intracardiac thrombus (a					
		art), and malignant neoplasm					
		be, left bronchus or lung.					
	(a cancer), rower re	oc, left brokenas of lang.					
	A review of Resider	nt 37's physican orders listed					
		cations, and their order dates,					
	without a diagnosis	listed for use:					
	a. "APLISOL 5T U						
		CC INTRADERMALLY EVERY					
		O AM [used for tuberculin					
	testing]"						
	b. "MORPHINE SI	JLF ER 15 MG TABLET GIVE					
		MOUTH EVERY 8 HOURS,					
		[narcotic pain medication]"					
		-					
	c. "ATORVASTAT	IN 40 MG TABLET TAKE					
		MOUTH DAILY AT 8PM,					
	12/26/22, 8:00 PM	[treats high cholesterol]"					
	d "MELATONIN 3	B MG TABLET TAKE ONE					
		TH ONCE A DAY AT					
		2, 8:00 PM [enhances sleep]"					
	DDD 111VID, 12/23/2	2, 0.00 i wi [cimanees sicep]					
	e. "TRAZODONE :	50 MG TABLET TAKE ONE					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/20/2023	
	PROVIDER OR SUPPLIEF	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD 7 34TH ST APOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAG		TH DAILY AT BEDTIME,	ING		DATE
		CL 15 MG TABLET GIVE ONE TH THREE TIMES A DAY, [anti-anxiety]"			
	~	HCL DR 30 MG CAP GIVE ONE ONCE A DAY, 11/10/22, 9:00			
	INJECT 17 UNITS	GLARGINE-YFGN U100 PEN SUBCUTANEOUSLY TWICE 1:26 AM [(treats elevated blood			
		100 MG CAPSULE GIVE 2 OUTH AT BEDTIME, 10/22/22, we pain]"			
	12 UNITS SUBCU	RO 100 UNIT/ML PEN INJECT TANEOULSY WITH MEALS [[treats elevated blood sugars]"			
		3.6-50 MG TABLET ABS AT BEDTIME 10/21/22, wents constipation]"			
	ONE TABLET BY	OTASSIUM 25 MG TAB GIVE MOUTH ONCE A DAY I [treats elevated blood			
	n. "ZOFRAN 4 MC EVERY 4 HOURS	TABLET GIVE ONE TABLET AS NEEDED FOR			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/20/2023	
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	NAUSEA/VOMITION. o. "NALOXONE HISPRAY IN EACH IN EACH IN EACH IN EACH IN IT END IT IN IT	NG 10/21/22, 12:00 PM" CL 4 MG NASAL SPRAY ONE NOSTRIL AS NEEDED FOR AY REPEAT TIMES ONE ES 10/21/22, 12:00 PM [narcotic rdose]" MG EMERGENCY KIT GIVE EOULSY TIMES ONE IF THAN 70 AND REPEAT AS NE IN 15 MINUTES 10/21/22, s sugar level in blood, treats HEN 325 MG TABLET GIVE 2 JAL 650MG BY MOUTH AS NEEDED FOR PAIN I [treats pain and/or fever]" IE 0.125 MG ODT GIVE ONE ITH EVERY 6 HOURS AS DOMINAL CRAMPING I [antispasmotic]" RIN 0.4 MG TABLET SL GIVE VERY 5 MINUTES AS NEEDED I, NOT TO EXCEED 3 DOSES IN EHEST PAIN PERSISTS, CALL ID PM" MG TABLET 1 TAB BY DAY 10/21/22, 10:00 AM			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE CO A. BUILDING B. WING	instruction 00	(X3) DATE SURVEY COMPLETED 01/20/2023	
	PROVIDER OR SUPPLIER VEST MANOR HEALTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	AM [use to treat high blood sugars]" v. "ELIQUIS 5 MG TABLET GIVE ONE TABLET BY MOUTH TWICE A DAY, 10/21/22, 9:11 AM [thins the blood]" w. "METOPROLOL SUCC ER 25 MG TAB 1 TAB BY MOUTH ONCE A DAY, 10/21/22, 8:00 AM [treats high blood pressure]" x. "ALLERGY (LORATADINE) 10 MG TAB 10MG BY MOUTH ONCE A DAY, 10/21/22, 8:00 AM [prevents or treats allergy symptoms]" On 1/20/23 at 1:25 p.m., during an interview, the Director of Nursing (DON) indicated the physician's orders should have all had an indication for use on each of the entered medication orders. A current policy, titled, "Medication Orders," with no date, was provided by the Director of Nursing (DON), dated 1/20/23 at 3:30 p.m. A review of the policy indicated, "Elements of the Medication OrderName of medicationStrength of medicationDosage and dosage formTime of Frequency of AdministrationRoute of AdministrationDuration of therapyDiagnosis or indication for use" 3.1-48(a)(4)				
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED	
		155041	B. Wl	ING		01/20/2023	
NAME OF I	PROVIDER OR SUPPLIE	}			ADDRESS, CITY, STATE, ZIP COD		
					34TH ST		
NORTHWEST MANOR HEALTH CARE CENTER			INDIAN	APOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the following cate	gories:					
	(i) Anti-psychotic; (ii) Anti-depressar	pt·					
	(iii) Anti-acpressar						
	(iv) Hypnotic	=					
	· ·	rehensive assessment of a					
	resident, the facili	ty must ensure that					
	\$492.45(a)(1) Day	sidents who have not used					
	- , , , ,	sidents who have not used s are not given these drugs					
		ation is necessary to treat a					
	specific condition as diagnosed and						
	documented in the	<u> </u>					
	§483.45(e)(2) Res						
		s receive gradual dose					
		ehavioral interventions,					
	to discontinue the	ontraindicated, in an effort					
	to discontinue the	se drugs,					
	§483.45(e)(3) Res	sidents do not receive					
	- , , , ,	s pursuant to a PRN order					
	unless that medic	ation is necessary to treat					
		ific condition that is					
	documented in the	e clinical record; and					
	\$483.45(a)(4) DD	N orders for psychotropic					
	- , , , ,	to 14 days. Except as					
		45(e)(5), if the attending					
		cribing practitioner believes					
		ite for the PRN order to be					
		14 days, he or she should					
		tionale in the resident's					
		d indicate the duration for					
	the PRN order.						
	\$483.45(a)(5).DD	N orders for anti-psychotic					
	. , , ,	to 14 days and cannot be					
	_	ne attending physician or					
	1	J 1 7	1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155041	B. WI	ING		01/20/2023
NAME OF L			•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF I	PROVIDER OR SUPPLIEF	C		6440 W	/ 34TH ST	
	WEST MANOR HEA	ALTH CARE CENTER	•	INDIAN	IAPOLIS, IN 46224	1
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE
	l	ioner evaluates the resident				
		eness of that medication. View and interview, the facility	EO	750	F 758	02/20/2022
		ropriate indications for use	F 07	/38	F 750 SS= E	02/20/2023
		with antipsychotic medications			It is the intention of Northwe	net
		reviewed for unnecessary			Manor Health Care Center to	
	medications (Residents	-			ensure appropriate indication	
	meanations (reside				for use of antipsychotic	,,,,,
	Findings include:				medications are documente	d.
	1. On 1/19/23 at 9:05 a.m., Resident 36's medical				What corrective action	
					will be accomplished to those	
	record was reviewed. He was a long-term care				residents found to have bee	
	resident with diagnoses which included but were				affected by the deficient	
	_	ecified dementia, psychotic			practice:	
	_	cinations and major depressive			Diagnoses found in each of the	ne
	disorder.				identified resident's health red	
					were added to the physician	
	His most recent cur	rent physician's orders			medication orders for	
	included an order for	or Risperidone (an			antipsychotic medications.	
		cation) 0.5 mg (milligrams).				
	_	included instructions to take			2. How other resident	
	-	at bedtime, the order lacked			having the potential to be	
	documentation of it	s indication for use.			affected by the same deficie	
					practice will be identified an	
		52 a.m., Resident 80's medical			that corrective action(s) will	be
		d. He was a long-term care			taken:	
	_	oses which included but were			The facility completed and au	
	not limited to undif	ferentiated schizophrenia.			for all residents to identify oth	er
	Ilia maatt	want uhrvaisianla au 1			medication orders without a	
		rent physician's orders			diagnosis indicated in the	
	included an order for	or Olanzapine (an cation) 5mg. Although the			medication order. Any other	out o
		ructions to give one tablet a			medication orders found with	
		tube, the order lacked			diagnosis indicating its use w corrected.	CIC
		s indication for use.			Corrected.	
	documentation of it	o maioanon foi use.			3. What measures will be	e
	During an interview	y on 1/20/23 at 9:20 a.m., the			put in place or what system	atic
	_	g (DON) indicated, she was			changes will be made to	
	_	ders did not have diagnoses			ensure that the deficient	
		the indication for the			practice does not recur:	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155041	B. W	NG		01/20/2023	
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			34TH ST		
NORTHA	VEST MANOR HEA	ALTH CARE CENTER			APOLIS, IN 46224		
NORTHV	VEST WANGETIEF	ALIII OAKL OLIVIER		INDIAN	AI OLIO, IIN 40224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	medications use wa	s required.			Education was provided to nui		
					on ensuring a proper diagnosi		
		a.m., the Administrator (ADM)			provided in a medication order		
		current, but undated facility			Physician orders are collected		
	policy titled, "Behavior and Psychoactive				from the nursing units and bro	ught	
	_	policy indicated, " The			to the clinical department		
	_	ent team will meet monthly to			meetings. The Director of Nurs	sing	
		nts receiving psychoactive			or designee will review the		
		Behavior Management			physician medication orders in		
		ure the prescriber's order for			clinical department meeting to		
		tion is based on the following:			ensure an indication is provide	ed in	
	a. Resident's diagno	osis"			the written order and EHR		
					system.		
	3.1-48(a)(4)						
					4. How the corrective		
					action(s) will be monitored to		
					ensure the deficient practice		
					will not recur, i.e., what quali	-	
					assurance program will be p	ut	
					in place:		
					The Director of Nursing or		
					designee will audit medication		
					orders for diagnosis or indicati		
					using a EHR report. The Direc		
					of nursing or designee will aud	lit	
					the report to verify each		
					medication has a diagnosis or		
					indication weekly for one mon		
					then twice a month for 2 month	,	
					then monthly for 3 months. Th	е	
					audit will begin 2/17/23. The		
					compliance rate is expected to	be	
					100%. The acceptable		
					compliance rate, established b	-	
					the QAPI team is 90%-100%.	lf	
					the threshold falls below the		
					target, the monitoring will cont		
					until a pattern of compliance is	3	
					established for 3 consecutive		
1			1		months of 00% 100% complia	nco	I

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER 155041	A. BUILDING B. WING	00 00	COMPLETED 01/20/2023
	ROVIDER OR SUPPLIER	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				rate. 5. By what date the systemic changes will be completed: 2/20/2023	
F 0761 SS=D Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accinstructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In an Federal laws, the franch biologicals in lunder proper temporation only authoritation access to the keysees \$483.45(h)(2) The	ang of Drugs and Biologicals cals used in the facility accordance with currently conal principles, and include cessory and cautionary ne expiration date when e of Drugs and Biologicals accordance with State and facility must store all drugs locked compartments cerature controls, and ized personnel to have see facility must provide			
	compartments for listed in Schedule Drug Abuse Preve 1976 and other druexcept when the fapackage drug distribe quantity stored dose can be readile			F 704	00/20/2023
	review, the facility feepired multi-dose v	on, interview, and record failed to date and remove vials of Tubersol (a liquid ujected under the skin to test	F 0761	F 761 SS= D It is the intension of Northwe Manor Health Care Center to	

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, ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		155041	B. W	ING		01/20/2023	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
NAME OF F	ROVIDER OR SUFFLIER			6440 W	/ 34TH ST		
NORTHV	VEST MANOR HEA	LTH CARE CENTER		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X	(5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPL	ETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DAT	TE .
	· · · · · · · · · · · · · · · · · · ·	om 2 of 2 medication room			label drugs and biologicals		
	_	led to remove an expired			used in the facility with		
	_	e eye drops that were opened			currently accepted profession		
		on carts reviewed (Resident 38			principles and the expiration		
	and 41).				date when applicable.		
					1. What corrective action		
	Findings include:				will be accomplished to thos		
					residents found to have bee	י	
	_	on of 100 hall medication room			affected by the deficient		
		a.m. a multi-dose vial of			practice:		
	Tubersol was observed inside the refrigerator.				Undated and expired medicat		
		ate to indicate when it was			identified during the surveyor'		
	opened.				audit were destroyed accordir	g to	
					facility policy.		
	_	on of 200 hall medication room					
		a.m., a multi-dose vial of			2. How other resident		
		ved in the refrigerator with a			having the potential to be		
	_	/22. The vial expired 30 days			affected by the same deficie		
	after opening.				practice will be identified an		
		00001.11			that corrective action(s) will	be	
	_	on of 200 hall medication cart			taken:		
	, ,	at 12:00 p.m., a transparent bag			The facility conducted an aud	t to	
		name contained a medication,			identify any other undated or		
		.2-1% drops lacked a date the			expired medications in medica		
		An insulin pen was observed the medication cart. The pen			carts and medication refrigera		
		esident 38's name and			to ensure no other residents v		
		argine 100unit/ml with a date			affected by the deficient pract	C C .	
	_	The insulin had expired.			3. What measures will be		
	opened 11/26/22. 1	пе пізиті най ехрпей.			put in place or what systema		
	A policy was provide	led by the Administrator on			changes will be made to		
		. It was titled, "Control of			ensure that the deficient		
		ated "labeling requirements			practice does not recur:		
		biologicals used in the facility			Nursing education was provid	ed on	
		accordance with currently			the proper labelling and storage		
		al principles, and include the			medications. A monthly audit		
	appropriate accesso				be done by a pharmacist on a		
		acturer's expiration date, and			least two medication carts and	l l	
	opened dated, when				refrigerators. A pharmacy	·	
	-panea autou, mien				reference for recommended		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COM		COMPL	ETED	
		155041	B. WING 01/20			01/20/	/2023
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224					
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-25(j) 3.1-25(m) 3.1-25(n)				expiration dates for medication will be available in the medica storage rooms and a binder available for the medication cad. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pin place: Director of Nursing or designed complete audits of medication carts and medication refrigerate to ensure medication storage labelling is compliant. The audity be completed weekly for ownouth, then twice a month for months and then monthly for the months. The audit process will start 2/20/2023. The compliant rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team 90%-100%. If the threshold fabelow the target, the monitoring will continue until a pattern of compliance is established for a consecutive months of 90%-10 compliance rate. 5. By what date the systemic changes will be completed: 2/20/2023	tion art. city ut e will tors and dits ne two hree I ce The is alls ng	

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