STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155041	A. BUILDING 00 B. WING	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHWEST MANOR HEALTH CARE CENTER	6440 W 34TH ST INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 1, 2, 3 and 4, 2024. Facility number: 000015 Provider number: 155041 AIM number: 100273750 Census Bed Type: SNF/NF: 96 SNF: 5 Total: 101 Census Payor Type: Medicare: 8 Medicaid: 62 Other: 31 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 16, 2024.	F 0000	*Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by the provisions of federal and state law.*	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals			

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

Bryce Reagan HFA | Administrator | 04/26/2024

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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	§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure expired medications were discarded and a resident's supplements were labeled for 2 of 2 medication storage areas reviewed for medication storage (Resident 72). Findings include: During a medication storage observation on 4/4/24 at 11:05 a.m., the Wing 1 medication room was observed. Inside the refrigerator was a bottle of tuberculin serum (used to test for tuberculosis (TB)). The bottle was undated and was a multidose vial. The Wing 2 Medication cart was observed. A bottle of pro-stat (a supplement used to aid in wound healing) which belonged to Resident 72 was not labeled with the required minimum information. During an interview on 4/4/24 at 11:01 a.m., the	F 0761	**F761 Label/Store Drugs and Biologicals** **SS- D** **It is the intension of Northwest Manor Health Care Center to label drugs and biologicals used in the facility with currently accepted professional principles and the expiration date when applicable.** **1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** Undated and expired medications identified during the surveyor's audit were destroyed according to facility policy. **2. How other resident having the potential to be affected by the same deficient practice will be identified and that**	05/06/2024

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	Director of Nursing (DON) indicated, all medications for residents should be properly labeled, and the TB serum should have been discarded. On 4/4/24 at 12:58 p.m., the DON provided a copy of current facility policy titled, "Storage of Medications," dated 9/18. The policy indicated, "...Drugs dispensed in the manufacturer's original container will carry the manufacturer's original expiration date. Once opened, these products will be acceptable to use until the manufacturer's expiration date is reached and unless the medication is: 1. In a multi-dose vial, 2 an ophthalmic medication, 3. An item for which the manufacturer has specified an unstable duration after opening ...." 3.1-25(j) 3.1-25(m) 3.1-25(n)		**corrective action(s) will be taken:** The facility conducted an audit to identify any other undated or expired medications in medication carts and medication refrigerators to ensure no other residents were affected by the deficient practice. **3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Nursing education was provided on the proper labelling and storage of medications. A weekly audit on proper labeling and storage will be completed weekly by a nursing manager. A monthly audit will be done by a pharmacist on at least two medication carts and refrigerators. A pharmacy reference for recommended expiration dates for medications will be available in the medication storage rooms and a binder available for the medication cart. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Director of Nursing or designee will complete audits of medication carts and medication refrigerators to ensure medication storage and labelling is compliant. The audits will be completed weekly for one month, then twice a month for two	

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			months and then monthly for three months. The audit process will start 4/29/2024. The compliance rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team is 90-100%. If the threshold falls below the target, the monitoring will continue until a pattern of compliance is established for 3 consecutive months of 90%-100% compliance rate. 5 **By what date the systemic changes will be completed:** 05/06/2024	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and			

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	serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure puree food items were properly prepared and mixed according to the recipe and the equipment was thoroughly washed and sanitized. This deficient practice had the potential to affect 8 of 8 residents who received pureed food from the kitchen. Findings include: On 4/4/24 at 9:24 a.m., Cook 13 was observed as he prepared pureed lunch for the afternoon meal service. Cook 13 was not observed to conduct hand hygiene. He indicated he had already measured out the vegetables and added water and a blender was observed full of mixed vegetables submerged in water. Cook 13 turned on the blender and after several minutes, indicated the vegetables were done. He did not add any additional ingredients. When he poured the mixture into a pan, it was observed to be very thin and watery. When asked what texture the puree should be, Cook 13 indicated, "just like this." When asked if he was going to add anything to the mixture, he indicated no, it was done, and he would put it on the stove to bring it to temperature and hold until lunch. When he finished with the vegetables, Cook 13 took the blender container and top to a 2-compartment sink. He turned on the tap water, rinsed the food particles from the blender, squeezed some down detergent into the container and used his bare, unwashed hands to swipe out the suds and remaining food particles. He did not	F 0812	**F 812 Food Procurement Store/Prepare/Serve-Sanitary SS- E** **It is the intention of Northwest Manor Health Care Center to prepare, distribute and serve food in accordance with professional standards for food service safety.** **1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** Education was provided to the cooks and assistant cooks on dysphagia and consistencies of mechanically altered diets. The same dietary staff members were also educated regarding facility policy and procedure for preparing mechanically altered diets. **2. How other residents having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** Education was provided to the cooks and assistant cooks on dysphagia and consistencies of mechanically altered diets. The same dietary staff members were also educated regarding facility policy and procedure for preparing mechanically altered diets. **3. What measures will be put in place or what systemic**	05/06/2024

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	allow for drying time and placed the dripping wet blender container back onto the base. When asked where/how he usually washed his equipment, Cook 13 indicated, sometimes he would take it across the hall to the dish room, but if he was in a hurry, he would just rinse it out there in the kitchen sink. Next, Cook 13 dumped pre-measured ground beef into the blender. He poured a large, unmeasured quantity of tap water in until the meat was covered and turned the blender on. After several minutes, he indicated it was done, and as he poured the pureed meat into a pan, it was observed to be very thin and watery. When asked about the texture, Cook 13 indicated, most of the water would steam out before lunch to create a thicker texture. During an interview on 4/4/24 at 9:35 a.m., the Dietary Manager (DM) was notified of the puree observations. The DM indicated that all dishes, utensils, and equipment should be run through the dish washing machine to ensure proper cleaning and sanitization. The DM indicated, pureed texture foods should not be too thin like a liquid, but more of the consistency of applesauce or pudding. At this time, copies of the vegetables and ground meat were requested. During a second observation on 4/4/24 at 10:04 a.m., Cook 13 was provided the recipes for the vegetables and ground meat, however he failed to properly measure out the ingredients and added an unknown quantity of bread with an unmeasured amount of gravy into the blender. He pureed the bread and gravy, then added it to the ground meat on the stove. The meat was still thin, so Cook 13 added an unmeasured amount of thickener into the pan and stirred until it reached		**changes will be made to ensure that the deficient practice does not occur:** Education was provided to cooks and assistant cooks concerning mechanically altered diets, food preparation, including using the amounts listed in recipes and serving sizes. Education was provided to dietary staff on the use of hand hygiene and the cleaning/sanitation of kitchen equipment used in food preparation. Dietary Manager or designee will conduct monthly audits on food preparation including serving size, sanitizing/cleaning, and hand hygiene. Substantial compliance is 100%. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Dietary Manager or designee will conduct audits of food preparation, sanitizing/cleaning and hand hygiene monthly to ensure processes are complaint. The hand washing and sanitizing/cleaning audit will be completed once a week for a month, twice a month for 2 months and then monthly for 3 months. The food preparation audit will be done for three meals per week for one month, three meals every 2 weeks for 2 months, and then 3 meals per month for 3	

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	an appropriate texture. Next, he added an unmeasured amount of thickener into the pan of mixed vegetables and stirred until it reached an appropriate texture. On 4/4/24 at 9:50 a.m., the DM provided copies of the recipes for mixed vegetables and cooked roast beef which provided specific and detailed instructions and measurements of ingredients, per serving size, that had not been followed during the observation. On 4/4/24 at 1:47 p.m., the Executive Director (ED) provided a copy of the current, but undated facility policy. The policy indicated, " ...Those residents who need pureed food shall receive a diet containing the same nutrient value as a regular diet. The pureed food will be seasoned as a regular diet and served at appropriate temperature and as attractively as possible. There is a menu written specifically for pureed diets. The recipe book details the method for preparation and serving size of pureed foods ...." 3.1-21(a)		months. The monitoring process will start 5/1/2024. Expected compliance is 100%. The acceptable compliance rate as determined by the QAPI team will be 90-100%. If the threshold falls below 90-100% compliance, the monitoring will continue until three consecutive months of 90-100% compliance is achieved. 5. **By what date the systemic changes will be completed:** 5/6/2024	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted			

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	professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident			

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	reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on observation, record review, and interview, the facility failed to accurately stage a pressure ulcer for 1 of 1 resident reviewed for pressure ulcers (Resident 71). Findings include: On 4/3/24 at 11:20 a.m., a record review was completed for Resident 71. She had the following diagnoses which included, but were not limited to, anemia (a condition in which the body does not have enough healthy red blood cells), hypertension (HTN), hyperlipidemia (HLD), type 2 diabetes, hypothyroidism, history of stroke (CVA), difficulty speaking, and depression. On 7/1/22, her pressure ulcer to her sacrum was referred to as an unstageable (full thickness tissue loss where the depth of the wound is completely obscured by eschar or dead tissue in the wound bed) pressure ulcer. On 7/3/23, a Wound Assessment Report indicated the resident had a stage IV (full thickness tissue	F 0842	**F842 Resident Records** **SS- D** It is the intention of Northwest Manor Health Care Center to provide documentation to accurately reflect the stage of a pressure ulcer. 1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice: A wound assessment was completed to identify the correct stage of the pressure ulcer identified during the survey. A MDS correction was made and submitted upon finding the identified inaccuracies on the resident identified during the survey. 2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective	05/06/2024

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	loss that extends through the fascia and may expose the muscle, bone, tendon, or joint) pressure ulcer to her sacrum. A Minimum Data Set (MDS) assessment, dated 7/8/23, was coded as resident having a stage IV pressure ulcer. On 7/28/22, her pressure ulcer to her sacrum was referenced as a stage IV. Resident 71 had a care plan dated 8/30/23. It indicated she had a pressure ulcer stage III to her sacrum. The goal indicated the wound would resolve with treatment. An intervention included to treat wound as ordered and weekly skin assessment. On 10/5/23, a Wound Assessment Report indicated resident had a stage III pressure ulcer to her sacrum. A MDS, dated 10/7/23, was coded as resident having a stage II (partial thickness loss of dermis that presents as a shallow open ulcer with a red or pink wound bed or an intact or ruptured blister) pressure ulcer. A MDS, dated 10/12/23, was coded as resident having a stage IV pressure ulcer. On 1/9/24, a Wound Assessment Report indicated resident had a stage III pressure ulcer to her sacrum. Resident's 1/7/24 MDS was coded as resident having a stage IV pressure ulcer. On 1/30/24, a Wound Assessment Report indicated resident had a stage III pressure ulcer to her sacrum.		action(s) will be taken: An audit was completed on all current pressure ulcer assessments to ensure clinical standards were followed regarding the staging of wounds. A MDS audit was completed with an MDS auditor to ensure MDS accuracy for sections related to the pressure ulcer staging. No other inaccuracies were found. 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Education on pressure ulcer assessment and the clinical standards of staging pressure ulcers was provided to nurses. Director of Nursing or designee will review wound documentation during the weekly wound meeting to ensure provider documentation and nursing documentation regarding staging agrees. Substantial compliance is defined as 85%. Audit process will start 4/29/2024. MDS auditor or designee will proof MDS assessment sections regarding pressure ulcer staging during their routine visit. Substantial compliance is defined as 95% accurate for 3 months. The audit process was started on 4/23/2024. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	On 2/6/24, a physician's progress note indicated resident had a stage III pressure ulcer to her sacrum that measured 1.4 centimeters (cm) in length by (x) 1.0cm in width x 0.5cm in depth. Resident's 2/9/24 MDS was coded as resident having a stage IV pressure ulcer. On 2/27/24, a Wound Assessment Report revealed a sacrum wound, stage III (full thickness tissue loss where subcutaneous fat may be visible, but bone, tendon, or muscle was not exposed). On 3/19/24, a Wound Assessment Report revealed a sacrum wound, stage III. She had a current physician's note, dated 4/1/24, which indicated Resident 71 had a stage III pressure ulcer to her sacrum. The wound was named "number 3." The treatment was changed to "collagen powder to promote extracellular matrix formation [an intricate network composed of an array of multidomain macromolecules organized in a cell/tissue specific manner] and autolytic debridement [a natural process by which endogenous phagocytic cells and proteolytic enzymes break down necrotic tissue] as no odor remains and, as such, no indication for Dakin's solution remains." During an interview with the Director of Nursing on 4/4/24 at 1:00 p.m., the DON indicated the MDS did not down stage pressure ulcers for the purpose of the MDS. They down staged according to current assessment of pressure ulcers. The RAI manual was referenced for accurate coding.		program will be put in place: Director of Nursing or designee will complete an audit on each pressure ulcer assessment to ensure clinical standards are followed when staging a pressure ulcer. Pressure ulcer staging will be verified with the facility certified wound nurse and physician providing wound services. Pressure ulcer assessment audits will be completed weekly for one month, twice monthly for 2 months and then monthly for 3 months. The compliance rate is expected to be 100%. The acceptable compliance rate established by QAPI team is 85-100%. If the compliance falls below the threshold identified by QAPI team, the monitoring will continue until a pattern of compliance is established for 3 months of 85-100% compliance rate. MDS coordinator or designee will present results of MDS audits in the Quality Assurance Performance Improvement committee meetings monthly. The expected accuracy rate will be 100% for 3 months or 3 MDS auditor visits. The acceptable compliance rate established by the QAPI team is 85-100%. If the 85%-100% threshold is met, the monitoring will end after 3 months of substantial compliance. If the threshold falls below the target, monitoring will continue until substantial compliance is	

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NORTHWEST MANOR HEALTH CARE CENTER	6440 W 34TH ST INDIANAPOLIS, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A policy titled, "Pressure Ulcer Prevention and Managing Skin Integrity," was provided by the DON on 4/4/24 at 12:58 p.m. It lacked documentation surrounding "reverse staging or back staging." The "NPUAP Position Statement on Staging, 2017 Clarifications January 24, 2017," indicated, " ...The NPUAP has long maintained this position and issued a position statement recommending against 'down staging' as early as the year 2006. One of the unintended consequences of identifying numerical stages of pressure injuries is that it invites the misinterpretation that 'stage' implies a progression (forward or backward). NPUAP's system implies no progression in any direction ...." According to CMS RAI version 3.0 manual, dated October 2023, " ...M0300, Step 1: determine the deepest anatomical stage. Pressure ulcers do not heal in reverse sequence, that is the body does replace the types and layers of tissue that were lost during pressure ulcer development before they re-epithelize. Clinical standards do not support reverse staging or back staging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals ...." 3.1-50(a)(1) 3.1-50(a)(2)		established for 3 consecutive months or 3 MDS auditor visits. 5. By what date the systemic changes will be completed: 5/6/2024	