STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155455	A. BUILDING 00 B. WING	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEYAN HEALTH CARE CENTER	729 WEST 35TH ST MARION, IN 46953

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00417630. Complaint IN00417630 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: October 12, 2023. Facility number: 000557 Provider number: 155455 AIM number: 100291240 Census Bed Type: SNF/NF: 97 SNF: 2 Total: 99 Census Payor Type: Medicare: 7 Medicaid: 59 Other: 33 Total: 99 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 20, 2023.	F 0000	This plan of correction is the center's credible allegation of compliance. 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 solely because it is required by the provisions of federal and state law. The facility respectfully request a desk review for compliance.	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

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

Debra Smith | DCS | 10/26/2023

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure timely administration of insulin per physician orders for 4 of 4 residents reviewed for insulin administration (Resident B, C, D and E). Findings include: 1. Resident B's clinical record was reviewed on 10/12/23 at 8:57 a.m. Diagnoses included type 2 diabetes mellitus without complications and type 2 diabetes mellitus with diabetic neuropathy. A quarterly Minimum Data Set (MDS), dated 8/17/23, indicated he was cognitively intact. He had a current care plan for fluctuating blood glucose levels related to diagnosis of diabetes (2/21/23). His interventions included he would receive his insulin as ordered (9/15/23) and he preferred to have his insulin before breakfast (revised 10/12/23). His Medication Administration Records (MAR) indicated the following: Insulin glargine (long-acting insulin) 30 units was scheduled to be administered on 9/4/23 at 9:30 p.m., and was administered on 9/4/23 at 6:48 p.m. Insulin glargine 30 units was scheduled to be administered on 9/16/23 at 9:30 p.m., and was administered on 9/17/23 at 1:08 a.m. Insulin glargine 30 units was not administered on 9/17/23 or 9/23/23 at 9:30 p.m. Novolog (short acting insulin) per sliding scale	F 0684	This plan of correction is the center's credible allegation of compliance. 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 solely because it is required by the provisions of federal and state law. The facility respectfully request a desk review for compliance. The residents affected by the alleged deficient practice have had orders reviewed to ensure timely administration of insulin. Residents that receive insulin have the potential to be affected by the alleged deficient practice. An audit of residents receiving insulin has been completed to ensure administration times are in compliance with the recommended times of administration and any that are outside those times have been corrected. Inservicing has been completed with nurses and QMAs on timely administration of insulin and timely documentation of insulin administration.	10/25/2023

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	was scheduled to be administered on 9/2/23 at 8:00 a.m., and was administered on 9/2/23 at 10:04 a.m. Novolog per sliding scale was scheduled to be administered on 9/15/23 at 8:00 a.m., and was administered on 9/15/23 at 9:51 a.m. During an interview with Resident B, on 10/12/23 at 9:49 a.m., he indicated he was considered a brittle diabetic. His meal trays were delivered to his room, and he had to wait to receive his insulin before he ate. By then, his food was cold. 2. Resident C's clinical record was reviewed on 10/12/23 at 9:27 a.m. Diagnoses included type 2 diabetes mellitus with hyperglycemia and morbid (severe) obesity due to excess calories. A significant change MDS, dated 9/7/23, indicated he was cognitively intact. He had a current care plan for fluctuating blood glucose levels related to diagnosis of diabetes (4/23/21). His interventions included he would receive his insulin as ordered (4/23/21). His Medication Administration Records (MAR) indicated the following: Insulin glargine 70 units was scheduled to be administered on 9/3/23 at 7:00 a.m., and was administered on 9/3/23 at 12:46 p.m. Humalog (short acting insulin) 8 units and per sliding scale was scheduled to be administered on 9/3/23 at 7:30 a.m. Both were administered on 9/3/23 at 12:45 p.m. Insulin glargine 70 units was scheduled to be		Nursing Management will perform random reviews documentation of insulin administration daily for timely administration of insulin. An audit will be completed daily Monday through Friday to determine if there are late administration of insulin. Insulin administration for residents will be placed in a time range that will ensure administration at resident preferred times as well as comply with the administration with meals when applicable. An audit tool will be used to determine compliance with insulin administration. An audit tool for insulin administration will be completed daily for 4 weeks, then 5 times a week for 4 weeks, then 3 times a week for 4 months or until 100% compliance is achieved and QAPI team determines ok to discontinue. Timely administration of insulin will be placed into QAPI for monitoring of compliance. Non-compliance will result in re-education and progressive discipline up to and including termination.	

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	administered on 9/12/23 at 7:00 a.m., and was administered on 9/12/23 9:51 a.m. Insulin glargine 70 units was scheduled to be administered on 9/16/23 at 7:00 a.m., and was administered on 9/16/23 at 9:51 a.m. Insulin glargine 50 units was scheduled to be administered on 9/16/23 at 8:00 p.m., and was administered on 9/17/23 at 2:19 a.m. Insulin glargine 70 units was scheduled to be administered on 9/23/23 at 7:00 a.m., and was administered on 9/23/23 at 9:03 a.m. Humalog 8 units was scheduled to be given on 9/23/23 at 5:30 p.m., and was administered on 9/23/23 at 7:42 p.m. Insulin glargine 50 units was not administered on 9/23/23 at bedtime. Insulin glargine 70 units was scheduled to be administered on 10/10/23 at 7:00 a.m., and was administered on 10/10/23 at 8:48 a.m. Humalog 8 units and per sliding scale was scheduled to be administered on 10/11/23 at 11:30 a.m. Both were administered on 10/11/23 at 1:40 p.m. Insulin glargine 70 units was scheduled to be administered on 10/12/23 at 7:00 a.m., and was administered on 10/12/23 at 9:31 a.m. Humalog 8 units and per sliding scale was scheduled to be administered on 10/12/23 at 7:30 a.m. Both were administered on 10/12/23 at 9:28 a.m.			

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	During an interview with Resident C, on 10/12/23 at 3:20 p.m., he indicated he liked to receive his pills and insulin before breakfast. Sometimes his insulin was not given to him before meals, and he had to ask for the insulin to be given. The staff would give him excuses as to why they had not given it to him and said they were too busy. 3. Resident D's clinical record was reviewed on 10/12/23 at 11:14 a.m. Diagnoses included type 2 diabetes mellitus with diabetic neuropathy, type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema and morbid (severe) obesity due to excess calories. A quarterly MDS, dated 7/3/23, indicated he was cognitively intact. He had a current care plan for being at risk for his blood sugars to fluctuate related to diabetes mellitus. He preferred regular pop, many snacks outside of diet, fast food, chips, etc. His blood sugar ran high due to his choices (12/9/22). His interventions included he would receive insulin per orders (12/12/22). His Medication Administration Records (MAR) indicated the following: Insulin glargine 45 units was scheduled to be administered on 10/1/23 at 3:00 p.m., and was administered on 10/1/23 at 5:07 p.m. Insulin glargine 45 units was scheduled to be administered on 10/2/23 at 3:00 p.m., and was administered on 10/2/23 at 5:15 p.m. Insulin glargine 45 units was scheduled to be administered on 10/4/23 at 3:00 p.m., and was administered on 10/4/23 at 5:05 p.m.			

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	Insulin glargine 45 units was scheduled to be administered on 10/5/23 at 7:00 a.m., and was administered on 10/5/23 at 10:58 a.m. Humalog per sliding scale was scheduled to be administered on 10/5/23 at 7:30 a.m., and was administered on 10/5/23 at 9:24 a.m. Insulin glargine 45 units was scheduled to be administered on 10/6/23 at 7:00 a.m., and was administered on 10/6/23 at 8:56 a.m. Insulin glargine 45 units was scheduled to be administered on 10/7/23 at 3:00 p.m., and was administered on 10/7/23 at 5:10 p.m. Insulin glargine 45 units was scheduled to be administered on 10/9/23 at 7:00 a.m., and was administered on 10/9/23 at 9:45 a.m. Humalog per sliding scale was scheduled to be administered on 10/10/23 at 7:30 a.m., and was administered on 10/10/23 at 9:37 a.m. Insulin glargine 45 units was scheduled to be administered on 10/11/23 at 7:00 a.m., and was administered on 10/11/23 at 9:58 a.m. 4. Resident E's clinical record was reviewed on 10/12/23 at 3:45 p.m. Diagnoses included anemia in chronic kidney disease, end stage renal disease, type 2 diabetes mellitus with diabetic neuropathy, and morbid (severe) obesity due to excess calories. A quarterly MDS, dated 8/26/23, indicated he was cognitively intact. He had a care plan for fluctuating blood glucose			

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	levels related to diagnosis of diabetes. He often ordered fast food and had snacks in his room (11/18/14). His interventions included he preferred to take his insulin after his meal instead of before my meals at times (4/10/23). His Medication Administration Records (MAR) indicated the following: Humalog per sliding scale were scheduled to be administered on 9/10/23 at 5:30 p.m., and was administered on 9/10/23 at 9:02 p.m. Insulin glargine 20 units was scheduled to be administered on 9/10/23 at 8:00 p.m., and was administered on 9/11/23 at 1:51 a.m. Insulin glargine 20 units was not administered on 9/23/23 at bedtime. Insulin glargine 20 units was scheduled to be administered on 10/7/23 at 8:00 p.m., and was administered on 10/8/23 at 1:10 a.m. Insulin glargine 20 units was not administered on 10/8/23 at bedtime. During an interview with Resident E, on 10/12/23 at 3:36 p.m., he indicated he was getting his insulin after meals and he didn't know why. During an interview with QMA 12, on 10/12/23 at 12:31 p.m., she indicated when she worked up front (Fireside hall), she would have the Fireside hall, the long hall of Willow and the Assisted Living hall. She tried to make it to Willow hall by 9:00 a.m. During an interview with RN 4, on 10/12/23 at 2:04 p.m., she indicated at times, a resident's blood			

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	sugar was low and she would see how much the resident ate before giving them insulin. Sometimes the resident was maybe in therapy and she would not go to therapy to give them insulin. During an interview with the DON, on 10/12/23 at 2:29 p.m., she indicated she felt the staff were not giving medications late, they were just documenting late. She had some staff who would document the medications given after the medication pass. Everyone knew medications should be documented as soon as they were administered. During an interview with LPN 13, on 10/12/23 at 2:47 p.m., she indicated medications could be documented at late because multiple residents may need assistance, or she would get stopped during her medication pass. Medications were always given on time especially her insulin's. It was her responsibility to document medications were given as soon as the medications were given. A current facility policy, titled "Medication Administration," provided by the DON, on 10/12/23 at 2:43 p.m., indicated the following: "...a. Documentation is completed on the MAR/eMAR immediately after medication(s) ingested by the resident...." This citation relates to Complaint IN00417630. 3.1-37(a)			