PRINTED: 10/27/2023

	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155455		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/12/2023	
NAME OF	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD EST 35TH ST		
WESLEYAN HEALTH CARE CENTER			MARION, IN 46953				
(X4) ID PREFIX TAG F 0000	(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
Bldg. 00	This visit was for the IN00417630.	ne Investigation of Complaint	F 00	000	This plan of correction is the center's credible allegation of		
	IN00417630. Complaint IN00417630 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: October 12, 2023. Facility number: 000557		compliance. Preparation a execution of this plan of co does not constitute admiss agreement by the provider truth of the facts alleged or conclusions set forth in the		compliance. Preparation an execution of this plan of corr does not constitute admission agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies. T	d/or rection on or of the	
	Provider number: 1002 AIM number: 1002 Census Bed Type: SNF/NF: 97	55455			plan of correction is prepare and/or executed solely beca is required by the provisions federal and state law. The facility respectfully requ	d use it of	
	SNF: 2 Total: 99				desk review for compliance.		
	Census Payor Type Medicare: 7 Medicaid: 59 Other: 33 Total: 99	e:					
	This deficiency refl accordance with 41	lects State Findings cited in 0 IAC 16.2-3.1.					
	Quality review con	npleted October 20, 2023.					
F 0684 SS=E Bldg. 00	applies to all treat facility residents. comprehensive as	a fundamental principle that ment and care provided to					

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

treatment and care in accordance with

(X6) DATE

TITLE

Debra Smith DCS 10/26/2023

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 AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER		729 WI	ADDRESS, CITY, STATE, ZIP COD EST 35TH ST NN, IN 46953		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PEGILIATORY OF LSC IDENTIFYING DISCOMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION
PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 0684	This plan of correction is the center's credible allegation of compliance. Preparation and/execution of this plan of correction of this plan of correction and compliance. Preparation and/execution of this plan of corrections and constitute admission 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 is required by the provisions of federal and state law. The facility respectfully request desk review for compliance.	10/25/2023 or etion or the set a
				alleged deficient practice have orders reviewed to ensure time administration of insulin.	ely
				Residents that receive insulin the potential to be affected by alleged deficient practice. An audit of residents receiving insulations are selected by the potential terms of the poten	the
				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 QN	n en MAs
				on timely administration of instand timely documentation of insulin administration.	ulin

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Novolog (short acting insulin) per sliding scale

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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 10/12/2023 155455 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 729 WEST 35TH ST WESLEYAN HEALTH CARE CENTER **MARION. IN 46953** (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 was scheduled to be administered on 9/2/23 at Nursing Management will perform 8:00 a.m., and was administered on 9/2/23 at 10:04 random reviews documentation of insulin administration daily for timely administration of insulin. Novolog per sliding scale was scheduled to be An audit will be completed daily administered on 9/15/23 at 8:00 a.m., and was Monday through Friday to administered on 9/15/23 at 9:51 a.m. determine if there are late administration of insulin. Insulin During an interview with Resident B, on 10/12/23 administration for residents will be at 9:49 a.m., he indicated he was considered a placed in a time range that will brittle diabetic. His meal travs were delivered to ensure administration at resident his room, and he had to wait to receive his insulin preferred times as well as comply before he ate. By then, his food was cold. with the administration with meals when applicable. An audit tool will 2. Resident C's clinical record was reviewed on be used to determine compliance 10/12/23 at 9:27 a.m. Diagnoses included type 2 with insulin administration. diabetes mellitus with hyperglycemia and morbid (severe) obesity due to excess calories. An audit tool for insulin administration will be completed A significant change MDS, dated 9/7/23, indicated daily for 4 weeks, then 5 times a he was cognitively intact. week for 4 weeks, then 3 times a week for 4 months or until 100% He had a current care plan for fluctuating blood compliance is achieved and QAPI glucose levels related to diagnosis of diabetes team determines ok to (4/23/21). His interventions included he would discontinue. Timely receive his insulin as ordered (4/23/21). administration of insulin will be placed into QAPI for monitoring of His Medication Administration Records (MAR) compliance. Non-compliance will indicated the following: result in re-education and progressive discipline up to and Insulin glargine 70 units was scheduled to be including termination. 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.

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Insulin glargine 70 units was scheduled to be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155455			ILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/12/	ETED		
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 729 WEST 35TH ST MARION, IN 46953					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		1	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	administered on 9/1							
		units was scheduled to be 6/23 at 7:00 a.m., and was 6/23 at 9:51 a.m.						
		units was scheduled to be 16/23 at 8:00 p.m., and was 17/23 at 2:19 a.m.						
	~ ~	units was scheduled to be 23/23 at 7:00 a.m., and was 23/23 at 9:03 a.m.						
		as scheduled to be given on as, and was administered on a						
	Insulin glargine 50 9/23/23 at bedtime.	units was not administered on						
	~ ~	units was scheduled to be /10/23 at 7:00 a.m., and was /10/23 at 8:48 a.m.						
	scheduled to be adn	nd per sliding scale was ministered on 10/11/23 at 11:30 ministered on 10/11/23 at 1:40						
		units was scheduled to be /12/23 at 7:00 a.m., and was /12/23 at 9:31 a.m.						
	scheduled to be adn	nd per sliding scale was ministered on 10/12/23 at 7:30 ministered on 10/12/23 at 9:28						

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/12/2023	
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			729 WE	ADDRESS, CITY, STATE, ZIP CO EST 35TH ST N, IN 46953)D		
(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 CORR (EACH CORRECTIVE A CTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	During an interview at 3:20 p.m., he indipills and insulin be insulin was not given had to ask for the inwould give him exercised given it to him and 3. Resident D's clim 10/12/23 at 11:14 a diabetes mellitus we diabetes mellitus we retinopathy without (severe) obesity during A quarterly MDS, a cognitively intact. He had a current case blood sugars to flue mellitus. He preferroutside of diet, fast sugar ran high due interventions include per orders (12/12/2). His Medication Ad indicated the follow Insulin glargine 45 administered on 10 Insulin glargine 45 administered on 10 administered on 10 Insulin glargine 45 administered on 10 administered on 10 Insulin glargine 45 administered on 10 Insulin glargine 45 administered on 10 Insulin glargine 45	with Resident C, on 10/12/23 iicated he liked to receive his fore breakfast. Sometimes his en to him before meals, and he issulin to be given. The staff cuses as to why they had not said they were too busy. iical record was reviewed on i.m. Diagnoses included type 2 ith diabetic neuropathy, type 2 ith unspecified diabetic to macular edema and morbid et to excess calories. Idated 7/3/23, indicated he was sere plan for being at risk for his cruate related to diabetes red regular pop, many snacks food, chips, etc. His blood to his choices (12/9/22). His died he would receive insulin 2). ministration Records (MAR) wing: units was scheduled to be /1/23 at 3:00 p.m., and was /1/23 at 5:07 p.m. units was scheduled to be /2/23 at 3:00 p.m., and was					

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administered on 10/4/23 at 5:05 p.m.

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CENTERS FOR MEDICARE & MEDICAID SERVICES	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER					COMPL		
155455		B. W	ING		10/12/	2023	
				STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER			729 WE	ST 35TH ST		
WESLEY	'AN HEALTH CARE	CENTER		MARION	N, IN 46953		
(X4) ID	SUMMARY 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 APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		+	TAG	DEFICIENCY)		DATE
	T 1' 1 ' 45	2 1 1 1 1 1 1					
		units was scheduled to be /5/23 at 7:00 a.m., and was					
	administered on 10/						
	administered on 10/	3/23 at 10.36 a.m.					
	Humalog per sliding	g scale was scheduled to be					
	administered on 10/	75/23 at 7:30 a.m., and was					
	administered on 10/	/5/23 at 9:24 a.m.					
	<u> </u>						
		units was scheduled to be					
		/6/23 at 7:00 a.m., and was					
	administered on 10/	76/23 at 8:56 a.m.					
	Insulin glargine 45	units was scheduled to be					
		7/23 at 3:00 p.m., and was					
	administered on 10/	-					
		-					
		units was scheduled to be					
		/9/23 at 7:00 a.m., and was					
	administered on 10/	/9/23 at 9:45 a.m.					
	II	lh- dal- da- h-					
		g scale was scheduled to be /10/23 at 7:30 a.m., and was					
	administered on 10/	*					
	administered on 10/	10/25 at 7.57 a.m.					
	Insulin glargine 45	units was scheduled to be					
		/11/23 at 7:00 a.m., and was					
	administered on 10/	/11/23 at 9:58 a.m.					
		ical record was reviewed on					
	_	m. Diagnoses included anemia in					
		ase, end stage renal disease,					
		litus with diabetic neuropathy,) obesity due to excess					
	calories.	obesity due to excess					
	caronios.						
	A quarterly MDS, d	lated 8/26/23, indicated he was					
	cognitively intact.	-					
	He had a care plan f	for fluctuating blood glucose					
	<u> </u>						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMB		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
155455		B. WING		10/12/2023		
NAME OF P	DROWNER OF CURRY TER		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C	729 W	EST 35TH ST		
WESLEY	'AN HEALTH CARE	CENTER	MARIO	DN, IN 46953		
(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 DEFICIENCY)		
TAG		gnosis of diabetes. He often	TAG	DEFICIENCE	DATE	
	I	and had snacks in his room				
		erventions included he preferred				
		fter his meal instead of before				
	my meals at times (
		ministration Records (MAR)				
	indicated the follow	nig.				
	Humalog per sliding	g scale were scheduled to be				
	administered on 9/1	0/23 at 5:30 p.m., and was				
	administered on 9/1	0/23 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 9/1	•				
	administered on 3/1	1/25 at 1.51 a.m.				
	Insulin glargine 20	units was not administered on				
	9/23/23 at bedtime.					
	1 1 1 20	% 1 1 1 1 · 1				
		units was scheduled to be				
	administered on 10/	/7/23 at 8:00 p.m., and was				
	administred on 10/	0/23 at 1.10 a.m.				
	Insulin glargine 20	units was not administered on				
	10/8/23 at bedtime.					
	<u></u>	'd D '1 (E 10/10/00				
	_	w with Resident E, on 10/12/23				
	_	icated he was getting his and he didn't know why.				
	mount and meals a	and no didn't know why.				
	During an interview	w with QMA 12, on 10/12/23 at				
	_	icated when she worked up				
	_	, she would have the Fireside				
	hall, the long hall o	f Willow and the Assisted				
	Living hall. She tri	ed to make it to Willow hall by				
	9:00 a.m.					
		M Day 4 4040422 2 2 2 2				
	_	w with RN 4, on 10/12/23 at 2:04				
	p.m., she indicated	at times, a resident's blood				

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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		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155455	B. WIN	IG		10/12/	2023
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 729 WEST 35TH ST MARION, IN 46953				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	 	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
		she would see how much the					
	resident ate before g	giving them insulin. Sometimes					
	the resident was ma	ybe in therapy and she would					
	not go to therapy to	give them insulin.					
	2:29 p.m., she indice giving medications documenting late. S document the medic medication pass. Ev	with the DON, on 10/12/23 at ated she felt the staff were not late, they were just he had some staff who would cations given after the veryone knew medications ted as soon as they were					
	2:47 p.m., she indicated at late I may need assistance during her medicational ways given on time was her responsibility.	with LPN 13, on 10/12/23 at ated medications could be because multiple residents e, or she would get stopped on pass. Medications were the especially her insulin's. It atty to document medications as the medications were					
	Administration," pro 10/12/23 at 2:43 p.n Documentation is co	olicy, titled "Medication ovided by the DON, on n., indicated the following: "a. completed on the MAR/eMAR nedication(s) ingested by the					
	This citation relates	to Complaint IN00417630.					
	3.1-37(a)						

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