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	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEYAN HEALTH CARE CENTER	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00413106, IN00413966 and IN00414590. Complaint IN00413106 - No deficiencies related to the allegations are cited. Complaint IN00413966 - No deficiencies related to the allegations are cited. Complaint IN00414590 - Federal/State deficiency related to the allegations is cited at F689. Survey dates: 8/10/23 -8/11/23 Facility number: 000557 Provider number: 155455 AIM number: 100291240 Census Bed Type: SNF/NF: 94 SNF: 1 Total: 95 Census Payor Type: Medicare: 4 Medicaid: 61 Other: 30 Total: 95 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 16, 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 requests a desk review for compliance.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra Smith	RN DCS	08/24/2023

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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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure supervision during dining for 1 of 4 residents reviewed for accidents. (Resident B) This deficient practice resulted in the resident choking and requiring placement on a ventilator at the hospital. Findings include: Review of a facility self-reportable to the State Agency, dated 8/5/23 at 7:01 p.m., indicated Resident B had an episode of choking at dinner time. The resident had a diet of pureed, and mechanical soft upon request, and was currently receiving speech therapy. During dinner, a table mate gave the resident a sandwich, which the resident began eating, and staff noticed the resident began choking. The nurse was notified and the resident required the Heimlich maneuver and suctioning to be done in the dining room. He was sent to the hospital. Resident B's clinical record was reviewed on 8/10/23 at 11:08 a.m. His diagnoses included chronic obstructive pulmonary disease (COPD), vascular dementia, oropharyngeal dysphagia, and hoarding disorder. A Minimum Data Set (MDS) assessment, dated 7/22/23, indicated he was severely cognitively impaired and required extensive assistance of one	F 0689	· - No residents were identified due to the nature of the survey. The resident identified from facility reported occurrence has returned to the facility and is eating at a table that is supervised by staff until meals are completed. Care plan has been updated and resident is receiving diet as ordered and speech therapy as ordered. · - Other residents that require supervision/cues and have mechanically altered diets have the potential to be affected by the alleged deficient practice. An audit of resident diets has been completed and an audit of residents requiring assistance with meals has been completed and dining room seating and care plans updated · - Inservicing completed with staff on dining room assignments and meal monitors have been put in place to observe the dining rooms and audit the diets to ensure correct diets. · - Monitoring tool will be used to monitor meals for correct diets and supervision daily at	08/18/2023

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	staff member for eating. Current physician orders, dated 4/6/22, indicated his diet was regular, pureed texture, with thin consistency liquids, and may have mechanical soft food items upon request with close supervision. A current careplan, dated 8/2/19, indicated his eating ability was at risk for decline related to his dementia diagnosis. Intervention approaches included to alternate solids and liquids: 3 to 1, cue me to pick up glass/cup and take a drink, cue me to pick up utensil and take a bite, cue me to take small bites/sips, lingual sweep and swallow, swallow completely before taking next bite, and finish meal with a liquid wash. An activities of daily living (ADL) careplan, dated 8/31/15, indicated he required assistance related to his dementia diagnosis. Intervention approaches included requiring supervision with set up for eating. A current cognition care plan, dated 7/12/22, indicated he would eat food off other people's trays. A current discharge summary, dated 8/5/23, indicated Resident B was hospitalized after a choking incident. The pulmonologist note included the diagnosis of acute left mainstem bronchus occlusion with food particle or foreign body (food stuck in his lung). The resident remained intubated (tube placed to assist with breathing) and transferred to a secondary hospital for further care and possible surgery options to remove the food obstruction. During an interview, on 8/11/23 at 10:15 a.m.,		random meals X 8 weeks, then 3 times weekly for 4 weeks, then weekly until QUAPI determines compliance. Monitoring will be reviewed in QUAPI a minimum of 6 months and until determined to be in compliance. .	

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	QMA 2 indicated staff had been told multiple times to watch Resident B while eating. He would take food from other people's tray and hide food items in his pockets to eat. She had caught him before with food that did not follow his diet order. The dining room assignment was supposed to be filled out daily so staff would be able to assist both in the dining room and with the residents remaining on the hall for meals. There should be two CNAs and one QMA from Harbour Lane, and one CNA from Willow Lane, at lunchtime in the dining room. Review of an 8/11/23 at 12:22 p.m. incident report and investigation of Resident B's choking, provided by the DON, indicated three staff members in the dining room during the meal service - CNA 3, CNA 4 and RN 5. The DON's interview with CNA 4 indicated he had transported residents back to their rooms and was not present in the dining room when Resident B choked. The investigation report lacked interviews with the two remaining employees present in the dining room at the time of the resident's choking. During an interview, on 8/11/23 at 12:26 p.m., the DON indicated she had confirmed the meal tray served to Resident B was pureed. The kitchen staff had served a ham sandwich to another resident, per request, who was sitting at the same table during dinner. During an interview, on 8/11/23 at 12:37 p.m., the DON indicated the care plan interventions requiring supervision during eating for Resident B were old and he no longer required those interventions.			

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	Resident B's speech therapy evaluation, dated for certification period 7/21/23-8/19/23, provided by the DON on 8/11/23 at 1:19 p.m., indicated the following recommendations: close supervision of oral intake, cues to slow rate of eating, and to alternate bites/sips frequently. During a phone interview, on 8/11/23 at 1:00 p.m., CNA 3 indicated she was assisting someone at the table for dependent residents, and had a view of Resident 14's profile at another table across the room. She did not remember what was on the tray in front of Resident B, but he had been seated with his roommate and another resident, or maybe two. CNA 4 and RN 5 had left the dining room prior to the resident choking. There were no staff members sitting at the table with Resident 14. CNA 4 and RN 5 were not available for interview during the survey. The National Dysphagia Diet, reviewed on 8/14/23 at 2:30 p.m., at https://www.cedars-sinai.org/health-library/tests-and-procedures/d/dysphagia-diet-level-1.html., indicated that patients with dysphagia diagnosis should eat only pureed food and avoid coarse foods. This Federal tag relates to Complaint IN00414590. 3.1-45(a)(2)			