STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155455	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesleyan Health Care Center	729 West 35th St Marion, IN 46953

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40241 Based on interview and record review, the facility failed to administer insulins as ordered and scheduled for 2 of 3 residents reviewed for insulin administration (Resident B and C). Findings include: 1. Resident B's clinical record was reviewed on 5/2/24 at 1:06 p.m. Diagnoses included type 2 diabetes mellitus without complications and type 2 diabetes mellitus with diabetic neuropathy. The current physician's orders included insulin glargine (long-acting insulin) 30 units subcutaneously at bedtime, tirzepatide (improve blood sugars) 10 mg (milligram) every seven days, and insulin aspart (short-acting insulin) per sliding scale subcutaneously before meals. The Medication Administration Records (MAR) indicated the following: Insulin glargine 30 units was scheduled for 3/23/24 at 8:00 p.m. and was administered on 3/23/24 at 11:44 p. m. Insulin glargine 30 units was scheduled for 3/24/24 at 8:00 p.m. and was administered on 3/25/24 at 1:41 a. m. Insulin glargine 30 units was scheduled for 4/20/24 at 8:00 p.m. and was administered on 4/20/24 at 11:37 p. m. Insulin aspart 4 units was scheduled for 4/21/24 at 5:30 p.m. and was administered on 4/21/24 at 10:33 p.m. 2. Resident C's clinical record was reviewed on 5/2/24 at 2:40 p.m. Diagnoses included type 2 diabetes mellitus with unspecified diabetic retinopathy without macular, type 2 diabetes mellitus with diabetic polyneuropathy, and type 2 diabetes mellitus with hyperglycemia. The March and April 2024 physician's orders included insulin glargine 25 units at bedtime. The MAR indicated the following: (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Insulin glargine 25 units was scheduled for 3/2/24 at 8:00 p.m. and was administered on 3/3/24 at 2:29 a.m. Insulin glargine 25 units was scheduled for 3/23/24 at 8:00 p.m. and was administered on 3/23/24 at 11:20 p. m. Insulin glargine 25 units was scheduled for 3/24/24 at 8:00 p.m. and was administered on 3/25/24 at 1:08 a. m. Insulin glargine 25 units was scheduled for 4/21/24 at 8:00 p.m. and was administered on 4/22/24 at 4:01 a. m. During an interview with the DON, on 5/3/24 at 1:26 p.m., she indicated the residents were given insulins on time, but the nurses were not documenting it at them time it was administered. A current facility policy, titled Timely Administration of Insulin, provided by the DON on 5/6/24 at 2:57 p.m., indicated the following: .Policy: It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. Policy Explanation and Compliance Guidelines: 1. All insulin will be administered in accordance with physician's orders .5. Procedure .e. Administer insulin at appropriate times. f. Document on the medication administration record the time and location of the insulin injection This citation relates to Complaint IN00432015. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 Based on observation, interview, and record review, the facility failed to ensure urinary catheter outputs were monitored and documented for 3 of 3 residents reviewed for urinary catheters (Residents D, H, and J), resulting in Resident D being transferred to the hospital with a large amount of urine retained from a blocked urinary catheter. Findings include: 1. Resident D's clinical record was reviewed on 5/2/24 at 1:22 p.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder, unspecified focal traumatic brain injury (TBI) with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, and need for assistance with personal care. The physician's orders included, but were not limited to, cefdinir (antibiotic to treat urinary tract infections) 300 mg via gastrostomy tube for five days, change catheter bag every 30 days and as needed, flush catheter with 30 ml (milliliters) daily and as needed (1/31/24), and flush catheter with 100 cc (cubic centimeter) daily and as needed for sediment (3/7/24). A 1/30/24, admission, Minimum Data Set (MDS) assessment indicated Resident D was rarely/never understood, and was dependent on staff for personal care and toileting. He had a urinary catheter. A current care plan indicated a problem of an indwelling catheter related to neurogenic bladder related to TBI (1/27/24). Interventions included change catheter system when clinically indicated or ordered (1/27/24), staff would care for his catheter, personal hygiene needs and proper positioning of the drainage bag (1/27/24), and staff to observe for changes in the color, consistency, and odor of urine, changes in mental status, changes in amount of urine produced, and pain in lower back or lower abdomen (1/27/24). Resident D's February and March 2024 urinary output documentation indicated the following: On 2/27/24 at 3:33 a.m., 250 cc (cubic centimeters)[a unit of measure] urine output and at 9:59 p.m., 500 cc urine output, totaling 750 cc of urine output for the day. On 2/29/24 at 5:16 a.m., 200 cc urine output. The clinical record lacked documentation of additional urine output. On 3/1/24 at 4:41 a.m., 300 cc urine output. The clinical record lacked documentation of additional urine output. On 3/3/24, the clinical record lacked urine output documentation. On 3/4/24, the clinical record lacked urine output documentation. On 3/5/24, the clinical record lacked urine output documentation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/6/24 at 5:29 a.m., 650 cc urine output and at 1:59 p.m., 750 cc urine output, totaling 1400 cc of urine output for the day. The history and physical note from a local hospital, dated 3/4/24 at 10:08 p.m., indicated Resident D was in the hospital with respiratory failure and was agitated. In the emergency department, it was discovered that Resident D's urinary catheter was clogged and upon changing the catheter, over a liter and a half (1500 cc) of urine had came out and Resident D felt a lot more comfortable. He would be admitted to the hospital with a urinary tract infection and started on Rocephin (antibiotic). The hospitalist impression/plan was (1) acute hypoxic respiratory failure, this was transient in nature and likely secondary to urine backup. (2) urinary tract infection (UTI), initiated Rocephin intravenously twice daily. (3) pressure ulcer, this was a known chronic entity. (4) encephalomacia (damaged brain tissue due to inflammation or bleeding); Resident D was chronically aphasic (unable to speak) secondary to TBI and subsequent encephalomalacia. The clinical record lacked indication of reason for transfer to the hospital on 3/4/24. During an interview with the DON, while reviewing Resident D's urinary output documentation, on 5/3/24 at 1:26 p.m., she indicated there was no documented urinary output for Resident D on 3/3/24. Resident D went out to the hospital on 3/4/24 at 5:30 a.m., and returned to the facility on [DATE] at 1:00 p.m. Sometimes, staff did not document the resident's urinary outputs. Resident D was non-responsive, but moaned at times during care. He tracked staff with his eyes at times. He had been in and out of the hospital for UTIs and respiratory problems. 2. Resident H's clinical record was reviewed on 5/6/24 at 10:31 a.m. Diagnoses included quadriplegia and retention of urine. The current physician's orders included 16 French Foley catheter (urinary catheter) with 30 cc balloon change once every 30 days, change catheter bag as needed every 30 day(s), change catheter as needed for occlusion and/or dislodgement every 24 hours as needed for replace catheter (2/29/24), change catheter bag as needed for if leaking (3/1/24), and urine output every shift at end of shift (5/6/24). A quarterly MDS assessment, dated 4/1/24, indicated Resident H was moderately cognitively impaired and required from substantial/maximal assistance to total dependence on staff for personal care. A current care plan indicated a problem of an indwelling catheter related to urinary retention/wounds (3/1/24). Interventions included change catheter system when clinically indicated or ordered (3/1/24), she would receive teaching on how to care for my catheter, personal hygiene needs, and proper positioning of the drainage bag (3/1/24), she would report and would observe for changes in the color, consistency, and odor of urine, changes in mental status, changes in amount of urine produced, and pain in the lower back or lower abdomen (3/1/24). Resident H's April and May 2024 urinary output documentation indicated the following: On 4/21/24 at 11:34 a.m., 600 cc urine output. On 4/22/24 at 3:40 a.m., 1000 cc urine output and at 9:58 p.m., 800 cc output, totaling 1800 cc of urine output for the day. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/23/24 at 5:23 a.m., 150 cc urine output and at 9:03 p.m., 1400 cc output, totaling 1550 cc of urine output for the day. The clinical record lacked urine output documentation for 4/24/24 through 4/27/24. On 4/28/24 at 7:03 a.m., 900 cc urine output and at 4:49 p.m., 1000 cc output, totaling 1900 cc of urine output for the day. On 4/29/24 at 12:20 p.m., 600 cc urine output and at 9:59 p.m., 725 cc output, totaling 1325 cc of urine output for the day. On 4/30/24 at 5:09 a.m., she had 950 cc urine output and at 8:16 p.m., she had 1000 cc output totaling 1950 cc of urine output. The clinical record lacked urine output documentation for 5/1/24 through 5/4/24. On 5/5/24 at 5:59 a.m., she had 950 cc urine output and at 1:52 p.m., she had 600 cc output totaling 1550 cc of urine output. 3. Resident J's clinical record was reviewed on 5/6/24 at 1:15 p.m. Diagnoses included, but were not limited to, other artificial openings of urinary tract status, neuromuscular dysfunction of bladder, benign prostatic hyperplasia without lower urinary tract symptoms, retention of urine, calculus of kidney, and hydronephrosis with renal and ureteral calculous obstruction. The current physician's orders included change catheter bag monthly and as needed, maintain suprapubic catheter 20 French/10 cc bulb and urine output every shift at end of shift (5/6/24). An admission MDS assessment, dated 3/7/24, indicated she was cognitively intact and was dependent on staff for personal care. Resident J had a care plan problem of a suprapubic catheter related to neurogenic bladder and urinary obstruction (6/22/22). Interventions included change catheter system when clinically indicated or ordered (8/7/23), consult with MD/NP as indicated (11/14/23), he would have extra fluids offered with medications (8/7/23), and he would report and staff would observe for changes in the color, consistency, and odor of urine, changes in mental status, changes in amount of urine produced, and pain in lower back or lower abdomen (6/11/22). Resident J's urinary output documentation indicated the following: On 4/21/24 at 5:59 a.m., he had 1700 cc urine output and at 10:44 p.m., he had 600 cc output totaling 2300 cc of urine output. On 4/22/24 at 3:28 a.m., he had 1200 cc urine output and at 5:17 p.m., he had 550 cc output totaling 1750 cc of urine output. On 4/23/24 at 5:21 a.m. he had 700 cc urine output. The clinical record lacked urine output documentation for the remainder of the day. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The clinical record lacked urinary output documentation for 4/24/24 and 4/25/24. On 4/26/24 at 5:50 a.m., he had 675 cc urine output. The clinical record lacked urine output documentation for the remainder of the day. On 4/28/24 at 4:48 a.m., he had 900 cc urine output and at 9:59 p.m., he had 800 cc output totaling 1700 cc of urine output. On 4/30/24 at 5:59 a.m., he had 2650 cc urine output and at 12:53 p.m., he had 600 cc output totaling 3250 cc of urine output. On 5/1/24 at 4:29 a.m., he had 900 cc urine output and at 1:59 p.m., he had 500 cc output totaling 1400 cc of urine output. The clinical record lacked urinary output documentation for 5/2/24 and 5/3/24. On 5/4/24 at 5:57 a.m., he had 650 cc urine output and at 9:59 p.m., he had 900 cc output totaling 1550 cc of urine output. On 5/5/24 at 5:59 a.m., he had 2000 cc urine output and at 11:55 a.m., he had 1100 cc output totaling 3100 cc of urine output. During an interview with LPN 34, on 5/3/24 at 3:36 p.m., she indicated the urinary catheters were to be emptied and the output amount documented every eight hours by the CNAs. The CNAs would notify the nurse if there was a concern with little to no output or if the urine was dark or foul smelling. The nurses checked to see if outputs were documented. During an interview with QMA 15, on 5/3/24 at 4:00 p.m., she indicated anyone could empty a catheter. The CNAs documented the outputs, and the catheters were emptied every shift and as needed. She would report discoloration, smell, or blood in the urine and if there was no to low urine output, to a nurse. During an interview with LPN 13, on 5/6/24 at 3:35 p.m., she indicated she forgot how to check the charting for urinary output, but Unit Manager 5 checked the charting to make sure it was completed. During an interview with RN 27, on 5/6/24 at 3:45 p.m., she indicated CNAs emptied the catheter bags and documented the urinary outputs. The nurses checked to make sure the documentation was completed and thought when it was not documented it will turn up red on the charting. During an interview with Unit Manager 5, on 5/6/24 at 3:39 p.m., she indicated herself and the nurses checked the CNAs' documentation. She checked day shift while she was working and then checked the other shifts' charting the following morning. If the urinary outputs were not documented, she would go to the resident's room first to make sure the catheter drainage bag wasn't full so it wasn't backing up into the resident's bladder, then she would counsel the staff for not documenting the outputs. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A current facility policy, titled Catheter Care, provided by the DON on 5/6/24 at 12:33 p.m., indicated the following: .Policy Explanation .8. Empty drainage bag every shift .Document care and report any concerns noted to the nurse on duty This citation relates to Complaint IN00432308. 3.1-41(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 40241 Based on observation, record review, and interview, the facility failed to ensure a resident received supervision per physician order and facility policy during the administration of a nebulized medication for 1 of 1 resident during a random observation. (Resident G) Findings include: During a random observation on 5/2/24 at 12:37 p.m., Resident G was lying in bed with a nebulizer mask on her face. A nebulizer machine was sitting on her bedside table and was in operation. There was no nurse present in the room, nor in the hallway. At 12:41 p.m., Nurse Manager 9 was passing hall trays for lunch and passed Resident G's room. At 12:44 p.m., Nurse Manager 9 entered Resident G's room, placed her tray on her overbed table, turned off the nebulizer machine, and placed the nebulizer mask on top of the machine. Resident G's clinical record was reviewed on 5/6/24 at 12:55 p.m. Diagnoses included, but were not limited to, morbid (severe) obesity with alveolar hypoventilation, obstructive sleep apnea, acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia, chronic obstructive pulmonary disease with (acute) exacerbation and acute on chronic diastolic (congestive) heart failure. The current physician's orders included budesonide 0.5 mg (milligram)/2ml (milliliter) inhale orally twice daily to be administered by clinician and ipratropium-albuterol inhale 3 ml twice daily to be administered by clinician. During an interview with Nurse Manager 9, on 5/2/24 at 12:51 p.m., she indicated Resident G should have been supervised during the nebulizer treatment. During an interview with LPN 13, on 5/6/24 at 3:35 p.m., she indicated she was supposed to supervise Resident G while receiving the nebulizer treatment, but another resident down the hall needed help with his shoes. A current facility policy, titled Nebulizer Therapy, provided by the DON, on 5/6/24 at 2:57 p.m., indicated the following: Care of the Resident .14. Observe resident during the procedure for any change in condition 3.1-47(a)(6)