

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Wesley on Grand		STREET ADDRESS, CITY, STATE, ZIP CODE 3520 Grand Avenue Des Moines, IA 50312	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interview, policy review and manufacturer's instructions, the facility failed to prime an insulin flexpen properly prior to administering insulin to a resident. The facility staff also removed the needle from the insertion site before the recommended amount of time in order to ensure the proper amount of insulin was administered for two of two residents observed who received insulin during medication pass (Resident #75 and #89). The facility reported a census of 59 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 had a diagnosis of diabetes. The MDS revealed the resident took insulin five of seven days during the look-back period. The Order Summary for Resident #75 dated 7/21/26 included a physician's order for Novolog (insulin) flexpen per sliding scale three times a day (TID) for diabetes started on 6/15/26. Administer 6 units of Novolog subcutaneously (SQ) if blood sugar 188-211. The Medication Administration Record (MAR) dated 7/1/25 - 7/31/26 revealed an order for Novolog insulin flexpen per sliding scale. The MAR revealed Staff A, Licensed Practical Nurse (LPN), documented Novolog insulin 6 units SQ administered the noon dose on 7/21/26. During observation on 7/21/26 at 12:23 PM, Staff A, LPN, reported Resident 75's blood sugar level was 197. Staff A checked the computer and reported Resident #75 had an order for sliding scale insulin and needed Novolog 6 units administered. Staff A obtained Resident #75's Novolog flexpen from the treatment cart. Staff A cleansed the end of the flexpen with an alcohol swab and attached a needle on the end of the pen. Staff A then turned the dial on the flexpen to 1 and pushed the button on the end of the flexpen as he held the pen horizontally. Staff A turned the dial on the end of the pen to 6 (units). Staff A inserted the Novolog flexpen needle into the resident's left lower abdomen, pushed the button on the end of the pen and removed the flexpen needle from the insertion site within 3-4 seconds. 2. The Electronic Health Record for Resident #89 revealed a diagnosis of Type 2 diabetes. The Order Summary for Resident #89 dated 7/21/26 included a physician's order for Novolog flexpen 15 units SQ TID for diabetes started on 7/17/26. The MAR dated 7/1/26 - 7/31/26 revealed an order for Novolog flexpen 15 units SQ TID started on 7/17/26. The MAR revealed Staff A, LPN, documented Novolog 15 units SQ administered the noon dose on 7/21/26. During observation on 7/21/26 at 12:33 PM, Staff A, LPN, reported Resident #89's blood sugar was 230. Staff A obtained a Novolog flexpen from the treatment cart, cleansed the end of the flexpen with an alcohol swab and attached a needle on the end of the pen. Staff A turned the dial on the flexpen to 1 and then pushed the button on the end of the flexpen as he held the pen horizontally. Staff A turned to dial to 15 (units). At 12:36 PM, Staff A donned a pair of gloves and cleansed Resident 89's left upper arm with an alcohol swab. Staff A inserted the Novolog flexpen needle into the skin, pushed the button on the end of the flexpen and removed the needle from the insertion site within 4 seconds. During an interview on 7/22/26 at 11:40 AM, Staff B, Assistant Director of Nursing (ADON) reported the process of preparing an insulin flexpen: The insulin (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pen should be dialed to 2, push the end of the pen and then check to see if insulin appeared at the end of the needle. Dial the insulin pen to the dose needed. Staff B stated the reason for priming the needle was to ensure the pen worked and the needle was not clogged. The ADON reported administer the insulin and hold the pen and needle in place for 30 seconds whenever an insulin flexpen used. In an interview on 7/23/26 at 10:45 AM, Staff B, ADON, reported she would look to see if they had a policy specific to insulin but she expected staff to follow the manufacturer's instructions for use and administration of insulin with a flexpen. A Medication Administration policy last approved 10/2025 revealed the policy established a standard for nurses to follow for medication administration. The authorized person will ensure prescribed medication is administered per the physician's order. The policy did not address insulin administration. An email dated 7/23/26 at 11:07 AM, the Associate Executive Director wrote our guidance is for nurses is to follow the manufacturer instructions (for insulin). Our Corporate clinical quality team recently brought to our attention that there are varying requirements for different insulin pens and products. We are planning to have this be part of an upcoming in-service to ensure all nurses are on the same page and administering in accordance with the product specifications. The Novolog manufacturer instructions revised 11/2019 revealed the following procedural steps whenever used a flexpen and gave a Novolog insulin injection: a. Pull the pen cap offb. Wipe the rubber stopper with an alcohol swabc. Pull the protective tab from the disposable needle and screw the needle tightly onto the flexpen. d. Remove the outer needle cap. e. Before each injection, a small amount of air may collect in the cartridge. To avoid injecting air and to ensure proper dosing, prime the pen. f. To prime the pen, turn the dose selector knob to 2 units. Hold the pen with the needle pointed up. Tap the cartridge holder gently to collect air bubbles at the top. Continue to hold the pen with the needle pointed up. Push the dose knob in. A drop of insulin should appear at the needle tip. Repeat steps until insulin seen at the tip of the needle, up to 6 times. g. To administer the insulin: Turn the dose knob to select the number of units (of insulin) needed to inject. Choose an injection site and inject the needle SQ under the skin of the stomach area, buttocks, upper legs or upper arms. Push the dose knob all the way in and continue to hold the dose knob in for at least 6 seconds before removing the needle to ensure the full dose administered.		