STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00441299, IN00441690, IN00442355, IN00443189, IN00443307, and IN00443304. Complaint IN00441299 - No deficiencies related to the allegations are cited. Complaint IN00441690 - No deficiencies related to the allegations are cited. Complaint IN00442355 - No deficiencies related to the allegations are cited. Complaint IN00443189 - State deficiencies related to the allegations are cited at R0217 and R0241. Complaint IN00443304 - State deficiencies related to the allegations are cited at R0217 and R0241. Complaint IN00443307- No deficiencies related to the allegations are cited. Survey dates: September 16 & 17, 2024 Facility number: 014706 Residential Census: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 23, 2024.	R 0000		
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility	R 0217	The deficiency has the potential to	10/17/2024

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

Verna Banks | Executive Director | 10/05/2024

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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	failed ensure a resident who was assessed as not able to administer insulin and complete blood sugar checks did not self-administer for 1 of 6 residents reviewed for medication administration. (Resident J) Findings include: The clinical record for Resident J was reviewed on 9/17/24 at 10:29 a.m. Diagnoses included postpolio syndrome, chronic respiratory failure, and diabetes mellitus type II. A SLUMS (Saint Louis University Mental Status) assessment, completed on 9/11/24, indicated the resident had a mild neurocognitive disorder. An admission Service Plan was completed on 9/11/24, and indicated the resident had difficulty understanding his needs for self-maintenance, but would cooperate when given direction or explanation. His ability to express himself was limited to making concrete requests regarding his basic needs. His judgement was poor, requiring cueing and supervision in planning, organizing and correcting daily routines. A self-administration of medication assessment was completed on 9/11/24 and indicated he required medications to be stored and locked. The resident's name was not indicated on the Medication Self-Administration list provided by the Administrator on 9/16/24 at 10:35 a.m. A current physician's order, dated 9/13/24, indicated a blood sugar to be obtained four times daily. The resident's electronic Medication Administration Record (eMAR) for September 2024, lacked an order to complete blood sugar testing four times a day.		affect all residents. Resident J medication was immediately removed and stored in the refrigerator in the medication room. All medications are being administered as ordered by residents provider and will be administered by either a licensed nurse or Qualified Medication Aide (QMA). The DON/Designee will audit each resident's medication assessment identifying all residents that need medication administration. Upon completion, the DON/Designee, with resident approval will audit each resident's apartment to ensure that there are no medications stored there for residents that clinical staff administer medications. The DON/Designee will re-train all nursing staff on medication management and storage procedures, adding the resident assessments which identify resident who require medication administration. All residents requiring medication management will be monitored weekly for one month. The DON/Designee will monitor the EMAR three times a week for the next month to ensure that all medications are being administered as ordered, then monthly for the next 5 months. Audits will be reviewed in the Quality Assurance Process Improvement (QAPI). All negative findings will be immediately	

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	During an observation on 9/17/24 at 2:00 p.m., accompanied by the Director of Nursing (DON), Resident J was observed in his room. He had insulin pens on his countertop. During an interview on 9/17/24 at 2:44 p.m., the DON indicated the resident had been testing his own blood sugars and administering his own insulin. He had his insulin pens in his room. He had not been assessed to do so, and staff should have been completing his blood sugars and injections. A current facility policy, revised 1/2024, titled, "Medication Management, Administration, & Storage," provided by the Administrator on 9/17/24 at 12:54 p.m., included the following: "Policy: A. Assessment: 1. The Director of Nursing, or licensed nurse designee, will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment.....2. If a resident is assessed as Needing Assistance with Medication Administration, it is the responsibility of the licensed nurse or Qualified Medication Aide (QMA) to administer the medications to the resident." This citation relates to Complaints IN00443304 and IN00443189.		corrected when identified and reported to the QAPI committee. The Executive Director is responsible for maintaining the compliance of this regulation.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on record review and interview, the facility failed to ensure residents received prescribed medications as ordered by a physician 4 of 5 residents reviewed for medication administration. (Residents E, G, H, and J)	R 0241	Residents had no negative effects for alleged deficiency. The deficiency has the potential to affect all Residents. No negative	10/17/2024

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	Findings include: 1. During an interview on 9/16/24 at 1:17 p.m., Resident E indicated she had to call and get herself to the emergency room due to her not receiving her medications and having two seizures the morning of 9/14/24. She indicated she had not received her medications on multiple occasions. She had never refused taking her medications and had pushed her call button to request her medications, but the staff had not answered. The clinical record review for Resident E was completed on 9/16/24 at 12:47 p.m. Diagnoses included anemia, blindness, dementia, diabetes mellitus type II, and seizure disorder. A SLUMS (Saint Louis University Mental Status) assessment, completed on 2/28/24, indicated the resident had dementia. A Level of Service Assessment was completed on 9/11/24, and indicated the resident understood information conveyed without difficulty, communicated information and was understood, and was sufficiently oriented to function independently if in familiar surroundings. Resident required caregiver assistance with glucose monitoring and insulin injections. A review of the resident's emergency department record, dated 9/14/24, indicated the resident had a history of left side seizure activity resulting from a history of stroke 12 years ago. The report indicated the resident had reported she had not received her medications for her seizure disorder which were to be administered three times a day, and she had not received them in two days. She indicated that her seizure activity had been well controlled previously. She was administered her		effects were noted for other residents. The DON in-serviced all nursing staff on the medication management procedures on September 20, 2024. The DON will audit the EMAR three times a week to ensure that all medications are being administered as ordered by the resident's provider. The DON/ED will ensure that there remains sufficient staff in number to meet the 24-hour schedule needs of the residents. The DON will review the EMAR three times a week and the medication orders to confirm that medications are being given on time and that medication orders are being refilled on time. Any issues will be brought to the attention of the Executive Director and the Pharmacy. The pharmacy will conduct a monthly audit and submit their findings to the DON and Executive Director, and any issues will be Immediately addressed. Audits will be reviewed in monthly QAPI meeting for 6 months. QAPI committee will make recommendations based off monthly audits. Compliance date October 17, 2024	

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	seizure medication in the emergency department. Current physician's orders and September 2024 eMAR reviews included, but was not limited to, the following: a. oxcarbazipine (used to control seizure disorder) 300 mg (milligram) three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. The order was dated 1/17/22. The electronic Medication Administration Record (eMAR) indicated the medication had not been administered on 9/8/24, 9/16/24 at 8:00 a.m.; 9/3/24, 9/4/24, 9/8/24, and 9/14/24 at 2:00 p.m.; 9/8/24, 9/9/24, and 9/15/24 at 8:00 p.m. b. Trulicity (to treat diabetes mellitus) 4.5 mg/0.5 ml (milliliter), inject 0.5 ml once weekly on Wednesday. The order was dated 4/3/24. A physician's order, dated 9/5/24, indicated to "Give trulicity now due to missed dose on 9/4/24, then resume normal schedule (every Wednesday)." The eMAR indicated the resident had not received her injection on 9/11/24. c. A review of the eMAR for September 2024, indicated the resident had not received any medications on 9/8/24 or the 6:00 a.m. or 8:00 p.m. doses on 9/9/24. A nurse practitioner's progress note, dated 9/12/24, indicated the resident reported she had not received her insulin three days in a row and there was an inconsistency as to if she received this. Her nightly insulin dose was increased due to ongoing hyperglycemia (high blood sugar). 2. During an interview on 9/17/24 at 9:00 a.m., Resident G indicated he had not been receiving his medications timely or at all on some days. He had several conditions that require regular			

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	medications to manage the symptoms and progression. He had never refused his medications and makes sure to be available in his room when his medications were due. Many times he received his insulin an hour or more after his meals. The clinical record review for Resident G was completed on 9/16/24 at 3:50 p.m. Diagnoses included Lewy body dementia, Parkinson's disease, and diabetes mellitus. A Level of Service Assessment was completed on 8/20/24, and indicated the resident understood information conveyed without difficulty, communicated information and was understood, and was sufficiently oriented to function independently if in familiar surroundings. Resident G required caregiver assistance with glucose monitoring and insulin injections. Current physician's orders and September 2024 eMAR reviews included, but was not limited to, the following: a. carbidopa-levodopa (to treat Parkinson's disease) extended release 50-200 mg, two tablets daily at 6:00 a.m., one tablet daily at 12:00 p.m., and 1/2 tablet daily at 4:00 p.m., and 1 tablet daily at 8:00 p.m. The order was dated 10/19/23. The eMAR indicated the medication had not been administered on 9/8/24, 9/9/24 at 6:00 a.m.; 9/8/24 at 12:00 p.m.; 9/16/24 at 4:00 p.m.; and 9/14/24 at 8:00 p.m. b. donepezil (to treat dementia) 10 mg daily at 6:00 a.m. The order was dated 11/8/23. The eMar indicated the medication had not been administered on 9/8/24 and 9/9/24.			

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	c. Jardiance (to treat high blood sugar) 10 mg daily at 6:00 a.m. The order was dated 4/24/24. The eMAR indicated the medication had not been administered on 9/8/24 and 9/9/24. d. memantine (to treat dementia) 5 mg twice daily at 6:00 a.m. and 10:00 p.m. The order was dated 10/19/23. The eMAR indicated the medication had not been administered on 9/8/24 and 9/9/24 at 6:00 a.m.; and 9/6/24, 9/14/24, and 9/16/24 at 10:00 p.m. e. novolin N (intermediate acting) insulin, inject 55 units twice daily at 6:00 a.m. and 10:00 p.m. The order was dated 11/15/23. The eMAR indicated the medication had not been administered on 9/8/24 and 9/9/24 at 6:00 a.m.; and 9/6/24, 9/13/24, 9/14/24, 9/15/24, and 9/16/24 at 10:00 p.m. f. Novolog (fast acting) insulin, inject medication per sliding scale, three times daily at 8:00 a.m., 12:00 p.m., and 4:00 p.m.: 140-200=18 units, 201-250=20 units, 251-300= 22 units, 301-350=24 units, 351-399=26 units. For greater than 400 or less than 70, call the physician. The order was dated 9/6/24. The eMAR indicated the medication had not been administered on 9/9/8/24 and 9/15/24 at 12:00 p.m.; and 9/15/24 at 4:00 p.m. g. Nuplazid (to treat Parkinson's disease) 34 mg daily at 6:00 a.m. The order was dated 10/18/23. The eMAR indicated the medication had not been administered on 9/8/24 and 9/9/24. h. Rasagliline (to treat Parkinson's disease) 0.5 mg daily at 6:00 a.m. The order was dated 10/19/23. The eMAR indicated the medication had not been administered on 9/8/24 and 9/9/24. i. Rybelsus (to treat diabetes mellitus) 7 mg daily at 6:00 a.m. The order was dated 8/16/24. The			

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	eMAR indicated the medication had not been administered on 9/8/24 and 9/9/24. A nurse practitioner's progress note, dated 9/12/24, indicated he was unable to evaluate and adjust the resident's sliding scale insulin due to lack of blood glucose checks since 9/4/24. It was unknown how effective the insulin was at controlling his blood sugars. 3. The clinical record for Resident H was completed on 9/16/24 at 3:28 p.m. Diagnoses included diabetes mellitus type II, anxiety, dementia, and peripheral vascular disease. A SLUMS assessment, dated 9/9/24, indicated the resident had dementia. A Level of Service Assessment was completed on 8/1/24, and indicated the resident understood information conveyed without difficulty, but may miss some part or intent of the message. He communicated information and was understood, and was sufficiently oriented to function independently if in familiar surroundings. Resident H required caregiver assistance with glucose monitoring and insulin injections. Current physician's orders and September 2024 eMAR reviews included, but was not limited to, the following: a. Check blood sugar four times daily at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. The order was dated 9/6/24. The eMAR indicated the blood sugar reading was not obtained on 9/13/24, 9/14/24, and 9/16/24 at 8:00 a.m.; on 9/8/24, 9/9/24, 9/13/24, and 9/16/24 at 12:00 p.m.; and on 9/6/24, 9/14/24, and 9/15/24 at 8:00 p.m. b. Humalog (rapid acting) insulin per sliding scale			

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	at 8:00 a.m., 12:00 p.m., and 4:00 p.m.: 150-200=3 units, 201-250=4 units, 251-300= 5 units, 301-350=6 units, 351-399=7 units. For greater than 400 or less than 70, call the physician. The order was dated 9/12/24. The eMAR indicated the medication had not been administered on 9/13/24 and 9/14/24 at 8:00 a.m.; on 9/12/24, 9/13/24, and 9/16/24 at 12:00 p.m.; and on 9/15/24 at 4:00 p.m. c. Novolog (rapid acting) insulin per sliding scale at 8:00 a.m., 12:00 p.m., and 4:00 p.m.: 150-200=3 units, 201-250=4 units, 251-300= 5 units, 301-350=6 units, 351-399=7 units. For greater than 400 or less than 70, call the physician. The order was dated 9/12/24. The eMAR indicated the medication had not been administered on 9/8/24 at 8:00 a.m.; and on 9/8/24 and 9/9/24 at 12:00 p.m. d. Trulicity 1.5 mg/0.5 ml, inject 0.5 ml weekly on Friday at 8:00 a.m. The order was dated 8/27/24. The eMAR indicated the medication had not been administered on 9/13/24. 4. The clinical record for Resident J was completed on 9/17/24 at 10:29 a.m. Diagnoses included diabetes mellitus type II, anxiety, high blood pressure and chronic respiratory failure. A SLUMS assessment, dated 9/11/24, indicated the resident had mild neurocognitive disorder. An admission Service Plan was completed on 9/11/24, and indicated the resident had difficulty understanding his needs for self-maintenance, but would cooperate when given direction or explanation. His ability to express himself was limited to making concrete requests regarding his basic needs. His judgement was poor, requiring cueing and supervision in planning, organizing and correcting daily routines.			

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	A review of the September 2024 eMAR, indicated the resident had not received his 8:00 a.m. medications on 9/3/24, 9/4/24, 9/5/24, 9/6/24, and 9/8/24, and had not received his 8:00 p.m. 9/1/24, 9/4/24, 9/5/24, 9/9/24, 9/14/24, 9/15/24, and 9/16/24 at 8:00 p.m. During a telephone interview on 9/16/24 at 1:59 p.m., the nurse practitioner (NP) indicated he had prescribed several orders for medications and treatments for residents that had not been processed. Blood sugar checks were not being completed as ordered and he had found it difficult to monitor insulin needs due to a lack of blood sugar values. Resident E had to go to the emergency room due to seizure activity that had been controlled with medication. She had not been receiving this medication as prescribed. The NP indicated the medication administration lately had been hit or miss. He was concerned about bad outcomes due to residents not receiving their prescribed medication. During an interview on 9/16/24 at 2:42 p.m., QMA 3 indicated she frequently passed medications to the whole building and was sometimes late administering them. She indicated certain agency staff nurses had not administered medications at all. The DON and Administrator were aware of these issues and indicate they were working on a plan to address the medication issue. During an interview on 9/16/24 at 3:25 p.m., the Administrator indicated she had been made aware of late medication administration and some missed medications. She had met with the DON and informed some medications were administered late, but not missed. During an interview on 9/17/24 at 9:40 a.m., the			

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	DON indicated she was not aware of missed medications. She received complaints regarding late medication administration. Medications should be given on time per facility policy and should never be missed unless the resident refused the administration. A current facility policy, revised 1/2024, titled, "Medication Management, Administration, & Storage," provided by the Administrator on 9/17/24 at 12:54 p.m., included the following: "...Policy:...B. Medication Administration: Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA. 1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation...." This citation relates to Complaints IN00443304 and IN00443189.			