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	01/27/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide daily grooming assistance for nail care for 2 of 3 residents reviewed for Activities of Daily Living (ADLs). (Resident 43, Resident 12) Findings include: 1. During an observation, on 1/20/26 at 3:38 p.m., Resident 43 had long fingernails with a dried, dirty substance under his nails.Resident 43's clinical record was reviewed on 1/23/26 at 2:07 p.m. Diagnoses included major depressive disorder, dementia, and epilepsy (disorder causing seizures).A quarterly Minimum Data Set (MDS) assessment, dated 12/8/25, indicated Resident 43 had moderate cognitive impairment. No behaviors were identified during the assessment period. He required partial/moderate assistance with personal hygiene.A current care plan, revised on 4/21/22, indicated Resident 43 required assistance with ADL's related to dementia and his ADLs fluctuated due to dementia and schizophrenia. Interventions included the following: Resident 43 required physical assistance of one for his a.m. and p.m. care and he needed physical assistance with bathing.During an observation, on 1/23/26 at 2:25 p.m., Resident 43's right thumb and index fingernails remained long and the third and fourth fingernails were chipped and jagged. His left thumb and index fingernails remained long, and the third fingernail was chipped and jagged.During an observation, on 1/27/26 at 9:54 a.m., Resident 43's right thumb and index fingernail remained long, and the third fingernail was jagged, chipped, and broke off at an angle.During an observation, on 1/27/26 at 11:07 a.m., CNA 15 indicated Resident 43's nails were long and needed trimmed.December 2025 and January 2026 shower sheets for Resident 43 were provided by the Corporate Nurse Consultant on 1/27/25 at 2:55 p.m. The most recent shower sheets indicated Resident 43 received showers on 1/13/26, 1/17/26, 1/20/26, and 1/24/26.2. During an observation on 1/27/26 at 10:14 a.m., Resident 12 had tan dried substance under seven of ten fingernails. Resident 12's clinical record was reviewed on 1/22/26 at 3:38 p.m. Diagnoses included cerebral palsy, profound intellectual disabilities, and aphasia (impaired ability to speak).A quarterly Minimum Data Set (MDS) assessment, dated 10/20/25, indicated Resident 12 was rarely or never understood. A staff assessment indicated Resident 12 had severe cognitive impairment. Resident 12 had functional limitation in range of motion to both upper and lower extremities. She was dependent for all of her care except eating, sit to stand, and toilet transfer, which were non-applicable. A current care plan, dated 6/23/23, indicated Resident 12 required assistance with ADLs related to cerebral palsy. Interventions included the following: Resident 12 required total assistance by two staff members for her a.m. and p.m. care.A current care plan, revised on 10/1/23, indicated Resident 12 was not able to communicate due to her diagnosis of cerebral palsy and she was unable to make her needs known. Interventions included the following: please provide Resident 12 with aromatherapy, hand messages, hair brushing/massages, and manicures during 1:1 programming visitation.During an observation, on 1/27/26 at 11:12 a.m., CNA 15 indicated Resident 12's nails were dirty and needed cleaned with an orange stick (a versatile, disposable, double-ended wooden tool essential for manicures and pedicures).December 2025 and January 2026 shower sheets for Resident 12 were (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2026
NAME OF PROVIDER OR SUPPLIER Wesleyan Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 729 West 35th St Marion, IN 46953	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided by the Corporate Nurse Consultant on 1/27/25 at 2:55 p.m. The most recent shower sheets indicated Resident 12 received a shower or bed bath on 1/12/26, 1/15/26, 1/19/26, and 1/22/26.During an interview, on 1/23/26 at 3:46 p.m., CNA 16 indicated fingernail care was to be completed by the CNAs at the time a resident received their shower. CNA 16 was unable to recall if nail care was listed on the shower sheets, but knew there was an area to document tasks completed, such as a linen change or shampooed hair. CNAs were responsible to trim and clean resident fingernails, but only if a resident requested it. Only nurses performed nail care for diabetic residents.During an interview on 1/27/26 10:08 a.m., QMA 17 indicated nail care was performed by CNAs on resident shower days and on an as needed basis. Nurses were responsible for performing nail care for residents with diabetes.During an interview on 1/27/26 at 10:30 a.m., RN 18 indicated resident fingernails were checked weekly by the CNAs, on each resident's shower day. The activity department usually performed nail care for the female residents, and the nurses were responsible to perform nail care on resident who were diabetic.During an interview on 1/27/26 at 11:07 a.m., CNA 15 indicated fingernail care was completed when a resident's nails were too long and/or dirty. Diabetic resident's nail care was performed by the nurses, otherwise CNAs were responsible. Nail care was part of each resident's regular routine and nail care was not documentedDuring an interview, on 1/27/26 at 12:49 p.m., the DON indicated residents received nail care on an as needed basis. Staff were to check resident nails on shower days.A facility policy, revised May 2017 and titled Personal Hygiene, provided by the DON on 1/27/26 at 12:40 p.m., indicated the following: Purpose: To ensure residents receive necessary care and assistance for personal hygiene tasks.Policy: 3. Nail care will be provided as needed. Diabetic nail care must be performed by a licensed nurse or podiatrist.3.1-38(3)(E)

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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. Based on interview and record review, the facility failed to follow physician orders regarding the administration of blood pressure medication according to ordered parameters for 1 of 5 residents reviewed for unnecessary medications (Resident 3). Finding includes:Resident 3's clinical record was reviewed on 1/22/26 at 9:50 a.m. Diagnoses included essential hypertension and atherosclerotic heart disease of native coronary artery without angina pectoris. Orders included losartan potassium (for blood pressure) 50 mg daily - hold if systolic blood pressure (SBP) (top number of reading) is less than 110 (1/21/25). A current care plan for hypertension, initiated 8/22/24 and revised 9/4/24, indicated the resident's goal was his blood pressure will be managed with his care plan interventions (initiated 8/22/24 and revised 1/10/26). Interventions included the resident's blood pressures will be taken as order and observed for any pattern changes and the resident will take his antihypertensive medications as ordered. The medication administration record (MAR) for 12/1/25 - 12/31/25 for the administration of losartan potassium 50 mg daily indicated the following: On 12/4/25 the resident's blood pressure (BP) was 109/50, on 12/5/25 the resident's BP was 101/52, on 12/25/25 the resident's BP was 108/64, on 12/26/25 the resident's BP was 109/79, and on 12/30/25 the resident's BP was 103/68. The MAR indicated the SBP was less than 110 on the above listed days, and the medication was not held. The MAR for 1/1/26 - 1/22/26 for the administration of losartan potassium 50 mg daily indicated the following: On 1/2/26 the resident's BP was 109/52, on 1/4/26 the resident's BP was 108/73, on 1/11/26 the resident's BP was 106/52, on 1/12/26 the resident's BP was 108/66, on 1/14/26 the resident's BP was 108/62, on 1/16/26 the resident's BP was 105/46, and on 1/21/26 was 107/55. The MAR indicated the SBP was less than 110 on the above listed days, and the medication was not held. During an interview, on 1/23/26 at 1:43 p.m., QMA 6 indicated some residents on her unit required monitoring of their blood pressure prior to medication administration. When the resident's blood pressure did not meet the parameters, she notified the nurse and waited for further instructions. The nurse was responsible to notify the physician. During an interview, on 1/27/26 at 9:39 a.m., QMA 20 indicated if the resident had blood pressure medication with ordered parameters, she held the medication if the blood pressure did not meet the parameters and notified the nurse. The nurse, sometimes, rechecked the resident's blood pressure, and gave the medication if the blood pressure met the parameters. She documented on the MAR if the medication was held and that she notified the nurse. During an interview, on 1/27/26 at 9:48 a.m., LPN 9 indicated when a resident received blood pressure medication, the blood pressure was taken prior to giving the medication. If a QMA took the blood pressure, LPN 9 rechecked the blood pressure. If the blood pressure was outside the parameters ordered, she held the medication. During an interview, on 1/27/26 at 1:04 p.m., QMA 6 reviewed the MAR and indicated she should have held the blood pressure medication when the resident's SBP was below 110. During an interview, on 1/27/26 at 1:15 p.m., the DON indicated she expected the staff to hold blood pressure medications if the blood pressure did not meet the ordered parameters. A current policy, last revised 4/2024, titled FOLLOWING PHYSICIAN ORDERS/PARAMETERS, provided by the Nurse Consultant on 1/27/26 at 3:01 p.m., indicated the following: .All licensed healthcare providers shall consult the resident's medical orders for the appropriate physician/clinician order prior to administering or performing a resident procedure. 1) Check MAR/TAR for physician/clinician order. 2) Licensed healthcare personnel will consult and follow the physician/clinician order when performing any resident procedures. 3.1-37(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent repeated falls for a cognitively impaired resident for 1 of 4 residents reviewed for accidents. (Resident 58) Findings include:During an observation, on 1/20/26 at 11:27 a.m., Resident 58 sat in her wheelchair at a dining table with a visitor. During an observation, on 1/21/26 at 9:10 a.m., Resident 58 sat in her wheelchair in the dining room with her head bowed and her eyes closed. During an observation, on 1/22/26 at 9:45 a.m., Resident 58 lay in her low bed with her eyes closed with her room door closed. Resident 58's clinical record was reviewed on 1/22/26 at 4:03 p.m. Diagnoses included dementia, major depressive disorder, recurrent, mild, bradycardia (slow heart rate), and atrial fibrillation (irregular heartbeat). Current orders included the following: may have bed against wall (9/20/25), losartan potassium (blood pressure) 12.5 mg daily - hold for SPB (systolic blood pressure [top number] less than 110 (2/27/25), sertraline (antidepressant) 50 mg daily (1/9/26), lorazepam (antianxiety) 0.5 mg every six hours as needed for anxiety/restlessness for 14 days (1/20/26), morphine sulfate concentrate 100 mg/5 mL - give 0.25 mL (5 mg) every four hours as needed for pain/air hunger (1/20/26), and tramadol 50 mg every six hours as needed for pain (1/6/26). A Minimum Data Set (MDS) assessment, dated 10/13/25, indicated the resident was severely cognitively impaired. She required partial/moderate staff assistance with showering/bathing, lower body dressing, putting on/taking off footwear, personal hygiene, moving from sitting to lying, moving from lying to sitting, chair/bed to chair transfers, toilet transfers, and walking 10 to 50 feet. She required substantial/maximal staff assistance with toileting hygiene and tub/shower transfers. She was frequently incontinent of bowel and bladder. She was short of breath with exertion. She had one fall with no injury since the prior assessment. A Minimum Data Set (MDS) assessment, dated 1/13/26, indicated the resident was severely cognitively impaired. She demonstrated disorganized thinking and inattention behaviors which fluctuated. She had verbal behavioral symptoms directed toward others that occurred one to three days during the assessment period. She required partial/moderate staff assistance with upper body dressing, putting on/taking off footwear, rolling left and right in bed, moving from sitting to lying, moving from lying to sitting, chair/bed to chair transfers, toilet transfers, and walking 10 feet. She required substantial/maximal staff assistance with toileting hygiene, showering/bathing, lower body dressing, and tub/shower transfers. She was frequently incontinent of bowel and bladder. She was short of breath with exertion. She had two or more falls with no injury, two or more fall with injuries, and one fall with a major injury since the prior assessment. A current care plan indicated the resident was at risk for falls related to not making good decisions, memory loss, history of falls, narcotic analgesics, and use of psychotropic medications. She had a fracture from a fall (initiated 2/25/25 and revised 1/19/26). Interventions included the following: 3 p.m. toileting (initiated 1/15/26), anti-roll back device used to lock wheelchair (initiated 1/20/26), encourage to stay in common areas while up in wheelchair and upon rising for the day (revised 11/17/25), wear non-slip footwear when in bed (initiated and revised 1/2/26), and when resident is restless, staff is to assist resident into wheelchair and into an area of increased supervision (12/28/25). A current care plan indicated the resident experienced a traumatic fracture (minimally displaced radial head fracture of right elbow) from a fall on 12/30/25 (initiated 1/6/26). Interventions included: the resident will follow up with orthopedic physician as scheduled. The resident refused to wear a sling (initiated 1/6/26) and refer to therapy as needed (initiated 1/6/26). A progress note, dated 12/24/25 at 4:45 p.m., indicated the resident sat in her wheelchair and attempted to transfer herself to her bed. The resident was found sitting on her buttocks on the floor beside her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNA indicated the resident had her shoes on, but she must have taken them off because the resident was only wearing her socks. A small bruise was noted to her right upper outer arm close to her elbow. Fifteen-minute checks were initiated, and non-skid slipper socks were placed on the resident. A progress note, dated 12/26/25 at 9:30 a.m., indicated the resident was walking to the bathroom and fell to the floor, with a large bowel movement noted on the floor. A fall IDT (interdisciplinary team) note dated 12/26/25 at 1:17 p.m., for the 12/24/25 fall at 4:15 p.m., indicated the resident was found sitting on the floor on her buttocks beside her bed. She had taken off her shoes and was wearing regular socks. The resident stated she was not hurt. The root cause of her fall was the resident was transferring without assistance, lost balance, and fell. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. She had a history of falls, but none within the past 30 days. Multiple interventions were in place prior to the fall. The immediate intervention was the placement of nonskid socks on the resident and initiation of 15-minute checks. A revised intervention was a pull tab chair alarm. A fall IDT note dated 12/26/25 at 1:37 p.m., for the 12/26/25 fall at 9:30 a.m., indicated the resident was found on the floor in her bathroom next to a pile of feces. The resident indicated she fell. The root cause of her fall was the resident was transferring without assistance, lost balance, and fell. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. The resident had a history of falls and already had a fall this week. Multiple interventions were in place prior to fall. The immediate intervention included assistance with resident's hygiene and updated bowel program. A progress note, dated 12/28/25 at 2:15 p.m., indicated the resident was found sitting on the floor beside the end of her bed. The resident could not explain to staff what she attempted to do. The wheelchair was close to the resident. The resident had her shoes on and had not been incontinent. No injuries were noted. Fifteen-minute checks were started. A fall IDT note dated 12/29/25 at 4:50 p.m., for the fall on 12/28/25 at 2:15 p.m., indicated the resident was found sitting on the floor in her room at the end of her bed. The resident was unable to state what happened. Her wheelchair was positioned near the resident. She was wearing appropriate footwear at the time of the fall. The root cause of the fall was that the resident was transferring without assistance, lost balance, and fell. During the investigation, it was found the resident was frequently standing to remove the chair alarm and place it in a variety of locations. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. The resident had a history of falls and already had a fall this week. Multiple interventions were in place prior to fall. The immediate intervention was placement of the resident on 15-minute checks. The revised interventions included removal of the chair alarm due to the staff report of it causing the resident to have increased restlessness. The resident transferred herself unassisted and placed the alarm in the bathroom. A progress note, dated 12/29/25 at 5:30 p.m., indicated the resident was found near her bed. She did not have shoes on, only socks. She attempted to self-transfer and slid off her bed trying to get into her wheelchair. A bruise was found on her right upper arm. Fifteen-minute checks were continued. A fall IDT note dated 12/30/25 at 9:58 a.m., for the fall on 12/29/25 at 5:30 p.m., indicated the resident was found lying on the floor next to her bed. Her head was by the bed, and her feet pointed away. The resident stated she slid out of bed. The root cause of her fall was the resident slid out of her bed onto the floor. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. The resident had a history of falls and already had a fall this week. Multiple inventions were in place prior to the fall. The immediate intervention was to place the resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back on 15-minute checks. The new intervention was to have the resident evaluated by the nurse practitioner (NP) for acute illness and to address pain. A progress note, dated 12/30/25 at 2:28 p.m., indicated the resident experienced right shoulder and elbow pain after her fall. She was seen by the NP. X-rays were ordered and reviewed. NP ordered a sling to be placed on the resident, and a repeat X-ray in one week. Tramadol 25 mg every six hours as needed was started. An x-ray of the right elbow with three views, completed on 12/30/25, indicated findings suggested fluid in the joint possibly due to a hidden radial head (top of the forearm bone where it meets the elbow) fracture. A progress note, dated 12/31/25 at 4:50 p.m., indicated the resident was found lying on the floor on her right side in her room. The wheelchair was by the window, and the resident was by the door. The resident was continent. She had one sock on her foot. Her shoes were by the bed. The resident was in her bed when the staff had last checked on her. No injuries were noted. Fifteen-minute checks were restarted. A fall IDT note dated 1/2/26 at 3:58 p.m., for the fall on 12/31/25 at 4:50 p.m., indicated the resident was found lying on the floor on her right side by the door. Her wheelchair was by the window. The resident had been in bed during the last check. The resident was unable to state what happened, but said she was not hurt. The root cause of the fall was the resident was ambulating without assistance, lost her balance, and fell. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. The resident had a history of falls and already had a fall this week. Multiple inventions were in place prior to the fall. The immediate intervention was to place the resident back on 15-minute checks. The revised intervention was to place non-skid socks on the resident while in bed. A progress note, dated 1/3/26 at 5:45 p.m., indicated the resident was found lying on her back beside her recliner near the bathroom door. The resident's wheelchair and shoes were in the bathroom. No injuries were noted. The resident was assisted off the floor and into her wheelchair. She was taken to the dining room for supper. A fall IDT note dated 1/5/26 at 3:04 p.m., for the fall on 1/3/26 at 6:06 p.m., indicated the resident was found lying flat on her back beside her recliner near the bathroom door. The resident's wheelchair and shoes were in the bathroom. The root cause of the fall was that the resident ambulated without assistance, lost her balance, and fell. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. The resident had a history of falls and already had a fall this week. Multiple inventions were in place prior to the fall. The immediate intervention was the resident was taken to an area of increased supervision. The revised intervention was that the toileting program was updated. A progress note, dated 1/6/26 at 5:16 a.m., indicated the resident was found lying on the floor on her fall mat. The resident indicated she put herself on the floor onto the fall mat and refused to get back in bed. The resident stated she was comfortable and did not want to get back into bed. An x-ray of the right elbow with three views, completed on 1/6/26, indicated a minimally displaced radial head fracture. A progress noted, dated 1/6/26 at 3:33 p.m., indicated the NP reviewed the repeat elbow x-ray. An appointment was made with the orthopedic provider. A progress note, dated 1/7/26 at 7:52 a.m., indicated the resident was found lying on the floor on her back at the bathroom doorway. The resident repeatedly stated she did not want the bed to get wet. No injuries were noted. Signage was added to the room that requested the resident to please use her call light. A fall IDT note dated 1/7/26 at 9:31 a.m., for the fall on 1/7/26 at 3:30 a.m., indicated the resident was found on the floor in her room in the doorway to her bathroom. She stated she did not want to get the bed wet. The root cause of the fall was the resident was ambulating without assistance, lost her balance, and fell. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident had a history of falls and already had a fall this week. Multiple inventions were in place prior to the fall. The immediate intervention was to hang a sign to remind the resident to call for help. The revised intervention was for labs to be drawn due to the increase in falls and behaviors. A progress note, dated 1/9/26 at 2:52 a.m., indicated the resident was sitting on the mat beside the bed on her buttocks. The resident came back from the bathroom and tried to transfer to the bed from her wheelchair and used the bedside table to get up out of the wheelchair. The CNA was in the hall and witnessed the resident try to use the bedside table for the transfer resulting in her falling on her buttocks onto the mat. No injuries were noted. The resident was assisted to bed, and 15-minute checks were initiated. A fall IDT progress note dated 1/9/26 at 4:46 p.m., for the fall on 1/9/26 at 1:45 p.m., indicated the resident was witnessed coming back from the bathroom to her bed. She attempted to transfer to the bed from her wheelchair and used the bedside table to get up out of the wheelchair. During the transfer, she lost her balance and fell to her bottom. The root cause of the fall was that the resident transferred herself and used the bedside table, lost her balance, and fell while getting into bed. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. The resident frequently refused to take her wheelchair when going to the bathroom. Staff attempted to give the resident her wheelchair, but she waved them off. The resident had a history of falls and fell multiple times this month. Multiple inventions were in place prior to the fall. The immediate intervention was that the resident was placed on 15-minute checks. The revised intervention was the placement of a nonskid strip next to the resident's bed. A progress note, dated 1/15/26 at 3:45 p.m., indicated the resident fell at 3:30 p.m. in the common bathroom. The resident wheeled herself out of the common bathroom. She requested to speak with her daughter and stated she fell in the bathroom. A fall IDT progress note dated 1/16/26 at 4:18 p.m., for the fall on 1/15/26 at 3:30 p.m., indicated the resident was seen coming out of the bathroom. She stated to staff that she needed to speak to her daughter because she fell while using the bathroom. No injuries were noted. The resident was not observed on the floor as the resident indicated she got herself up. The staff assisted the resident to the bathroom. The root cause of the fall was behavioral. When resident found out the daughter was unable to visit like she usually did on Thursdays, the resident indicated she had fallen. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. The resident had a history of falls and had fallen multiple times this month. Multiple inventions were in place prior to the fall. The immediate intervention was to bring the resident to an area of increased supervision. The revised intervention was to update the toileting program. A progress note, dated 1/18/26 at 9:00 a.m., indicated the resident wheeled herself back to her room after breakfast. A few minutes later, the resident was heard yelling help me. She was found sitting on the floor between her wheelchair and her bed. No injuries were noted. She was placed in her wheelchair and taken to the television room as she requested. A fall IDT progress note dated 1/19/26 at 5:33 p.m., for the fall on 1/18/26 at 9:00 a.m., indicated the resident was heard calling out for help. She was found sitting on the floor between her bed and her wheelchair. The resident wore appropriate footwear. The resident stated she was trying to get back in her bed. The root cause of the fall was the resident was transferring herself without assistance, lost her balance, and fell while getting in bed. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. The resident had a history of falls and had fallen multiple times this month. Multiple inventions were in place prior to the fall. The immediate intervention was placement of the resident on hourly checks. The revised intervention was to continue the hourly checks (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the resident. A progress note, dated 1/20/26 at 2:46 p.m., indicated, at 9:40 a.m., the resident was in her wheelchair when the staff left her room. She got on the floor after they turned around. The psychiatric-mental health NP spoke with the resident, and antiroll back devices were placed on the resident's wheelchair. A fall IDT progress note dated 1/20/26 at 5:11 p.m., for the fall on 1/20/26 at 9:40 a.m., indicated the staff had just assisted the resident into her wheelchair as she requested. As the staff exited the room, the resident stated she was on the floor. The resident was lying on her right side with her hand underneath her head between her bed and her wheelchair. She declined to answer questions about her fall, but stated she would do it again until her daughter came in. No injuries were noted. The root cause of the fall was the resident was transferring herself without assistance, lost her balance, and fell while getting into bed. Contributing factors included multiple diagnoses and severe cognitive impairment. She had dementia and demonstrated poor safety awareness. The resident had a history of falls and had fallen multiple times this month. Multiple inventions were in place prior to the fall. Anti-roll back devices were added to the resident's wheelchair, and her daughter came in to visit her. During an observation, on 1/22/26 at 2:47 p.m., the resident was lying in her low bed with her eyes closed. The door was open. During an observation, on 1/23/26 at 10:12 a.m., the resident was lying in her low bed with her eyes closed. The door was open. During an interview, on 1/23/26 at 1:38 p.m., QMA 6 indicated the resident had worn a sling on her arm for a short time. To prevent falls, the resident wore nonskid socks, had nonskid strips in front of her bed and toilet, her bed was in lowest position, her call light was within reach, a non-slip mat was on her wheelchair, she was kept in the common area when awake, and her room door was kept open when she was in bed. During an observation, on 1/23/26 at 4:14 p.m., the resident was lying in her low bed with her eyes closed. The door was closed. During an interview, on 1/23/26 at 4:19 p.m., CNA 8 indicated, to prevent the resident from falling, she gave her snacks, played a card game called garbage with the resident, and tried to distract her when the resident became restless. The specific interventions for falls were listed on the Kardex for all the residents. During an interview, on 1/27/26 at 12:58 p.m., CNA 7 indicated to prevent the resident from falling, she took the resident on walks. The resident also loved to read her Bible. The resident also liked to sit in her room and look out the window. The staff tried to keep her door open so they could keep an eye on the resident. The CNAs could look on the Kardex to see specific fall interventions for the residents. During an interview, on 1/27/26 at 1:08 p.m., Unit Manager 5 indicated the resident had fallen a lot lately. Some of those falls she attributed to maladaptive behaviors. The NP had seen the resident and believed the resident ran bradycardic (low heart rate) and that may have caused her falls. The cardiologist indicated a pacemaker was not warranted for the resident due to her age. The staff tried to keep the resident in common areas. They assisted her to bed between meals. Unit Manager 5 expected the door to remain open while the resident was in bed, but the roommate got up and closed the door at times. She indicated it was the roommate's right to have the door closed. During an interview, on 1/27/26 at 1:17 p.m., the DON indicated the resident had fallen multiple times in the last 30 days. The DON always staffed two to three staff members on the secured unit. The resident used to take care of herself and continued to try to get up on her own. The DON indicated the staff tried to keep the resident out of her room as much as possible, but that caused the resident to have behaviors. During an interview, on 1/27/26 at 3:01 p.m., the ADON indicated she believed a lot of the resident's falls were behaviors and associated with her heart. The family refused to pursue treatment for her heart condition. The staff tried to keep the resident out of her room as much as they could. During an interview, on 1/27/26 at 3:08 p.m., the DON indicated she felt like the facility had done everything they could to (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent the resident from falling. A current facility policy, last revised 8/2024, titled Fall Investigation and Risk Evaluation, provided by the Nurse Consultant on 1/27/26 at 3:01 p.m., indicated the following: .It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assisted devices to prevent avoidable accidents. ‘Avoidable Accident' means that an accident occurred because the facility failed to: . Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident. 3.1-45(a)(2)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. A. Based on observation and interview, the facility failed to ensure food was prepared and served under safe and sanitary conditions regarding food handling and hand washing. This deficient practice had the potential to impact 100 of 102 residents who received their meals from the kitchen.B. Based on observation and interviews, the facility failed to store, prepare, and distribute food under safe sanitary conditions regarding the removal of dented food cans. This deficiency had the potential to impact 100 of 102 residents who received their meals from the kitchen.Findings include:A1. During a lunch service observation, on 1/20/26 at 11:57 a.m., the following food handling service concerns were observed:CNA 7 propelled a male resident to his seat in the dining room. CNA 7 then walked over and adjusted another male resident in his high back wheelchair. She grabbed the adjustment handle of his high back wheelchair and adjusted the resident forward, so he wasn't leaning back as far. After adjusting the male resident's wheelchair, CNA 7 grabbed a meal tray from the covered meal cart. She walked over to Resident 2 and placed the food in front of her. CNA 7 picked up the single piece of bread that was wrapped in plastic, and unwrapped the plastic and touched the piece of bread with her bare hands before placing it on the plate in front of Resident 2. No hand hygiene was performed in between touching the two male residents' wheelchairs and grabbing the meal tray.During an interview, on 1/20/26 at 12:11 p.m., CNA 7 indicated she did not perform hand hygiene after touching the two male residents wheelchairs, and she should not have touched Resident 2's bread with her bare hands. A2. During a lunch service observation, on 1/20/26 at 12:20 p.m., the following food handling and food service concerns were observed:Dietary Employee (DE) 13 pulled her hairnet down below her ears and touched her cheeks while waiting for a tray.DE 14 touched the inside portion of a bowl with his left thumb before placing food inside the bowl. Later in the observation, DE 14 touched the inside of a bowl with his left thumb, pointer and middle finger before placing mashed potatoes inside the bowl.The Assistant Dietary Manager placed four small pieces of chicken on a plate. He used his thumb and pointer finger to place the chicken together on the plate. Later in the observation, he placed the food portion of the plastic bowl covers against his shirt to help separate them. DE 13 bit on her right ring finger around her nail before she proceeded to touch the food portion of the plastic bowl covers. No hand hygiene was performed.DE 13 was observed using a fork and her bare fingers to remove the skin off a baked potato.During an interview, on 1/20/26 at 12:48 p.m., the Dietary Manager indicated DE 13 should have washed her hands after touching her face and adjusting her hair net. DE 13 should not have used her hands to remove skin off the potato. She should have used utensils. Her staff should not touch the inside food portion of bowls/plates/ or plastic food covers. Staff should not touch food with their bare hands.On 1/20/26 at 12:56 p.m., the Assistant Dietary Manager indicated he didn't recall placing the plastic bowl covers against his shirt or touching the food portion of the cover.On 1/20/26 at 1:03 p.m., DE 13 indicated she was not sure if she washed her hands after touching her face, but felt she probably did not. She did use a fork and her fingers when taking skin off the potato, but her bare hands did not touch the potato, just the skin part she removed. She should not have used her hands to remove the skin. She did not recall touching the food portion of the plastic bowl covers.On 1/20/26 at 1:05 p.m., DE 14 indicated he was rushing and his fingers could have gone into the food portion of the bowls.During an interview, on 1/22/26 at 1:26 p.m., Resident 48 indicated she had seen a lot of hygiene practice issues during meal service. She had seen staff touch/rub their face and arms without washing their hands afterwards. B1. During a kitchen observation, on 1/20/26 at 9:37 a.m., accompanied by the Dietary Manager, the following was observed:In the facility's dry storage area, one can of sliced (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	apples was dented on the top seal. It had an intake date of 1/13/26. A can of peas and diced carrots had a dented seal with an intake date of 1/12/26. And a can of basic cheddar cheese had a dented bottom seal with an intake date of 1/9/26.The Dietary Manager indicated the dented cans should have been removed and placed on the upper shelf to receive credit from the supplier. There was signage posted to the left side of the can rack informing staff members what to look for regarding canned food.A current facility policy, dated 4/9/24, titled Food Safety Requirements, provided by the Administrator, on 1/27/26 at 11:43 a.m., indicated the following: .7b. Staff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli paper, and spatulas A current facility policy, dated 7/2008 and revised on 6/21, titled Personal Hygiene and Jewelry, provided by the Administrator, on 1/27/26 at 11:43 a.m., indicated the following: .7. All employees of the Dining and Nutrition Services department shall follow approved policy and procedure for hand washing A current facility policy, dated 3/2025, titled Dented Cans, provided by the Administrator, on 1/27/26 at 11:43 a.m., indicated the following: .4a. There are two types of seams on a can: side and end seams. Side seams are on the side of the can and are usually covered by the label. End seams are on the top and bottom of the can. If there is a dent over any of these seams, the can has at least one major defect, meaning that it is unsafe 3.1-21(i)(3)

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to utilize infection control prevention and control practices for residents requiring enhanced barrier precautions (EBP) for 1 of 3 residents reviewed for infection control. (Resident 12) Finding includes: During an observation, on 1/20/26 at 3:38 p.m., Resident 12 was receiving a continuous enteral (tube) feeding. An magnet indicating EBP hung on the outside doorframe of Resident 12's room.Resident 12's clinical record was reviewed on 1/22/26 at 3:38 p.m. Diagnoses included cerebral palsy, dysphagia (difficulty swallowing), and gastrostomy status (a gastric feeding tube).Current physician orders included enhanced barrier precautions (5/14/24), provide g-tube care on day shift (7/10/25), and administer Osmolite (tube feeding formula) 1.2 at 49 milliliters every hour per PEG (percutaneous endoscopic gastrostomy)[feeding] tube, flush with 116 milliliters of free water every four hours, and change tube feeding tubing every shift (3/17/25).A quarterly Minimum Data Set (MDS) assessment, dated 10/20/25, indicated Resident 12 was rarely or never understood. A staff assessment indicated Resident 12 had severe cognitive impairment. Resident 12 had functional limitation in range of motion to both upper and lower extremities. She was dependent in all of her care except eating, sit to stand, and toilet transfer which were non applicable. Resident 12 had a feeding tube and received 51% or more of her total calories through tube feeding.A current care plan, revised on 3/29/24, indicated Resident 12 had a gastrostomy tube related to dysphagia and received nothing by mouth. Interventions included the following: orders for site care will be followed (6/23/23).A current care plan, revised 4/17/24, indicated Resident 12 required enhanced barrier precautions due to her gastrostomy tube. Interventions included the following: staff will follow enhanced barrier precautions with her care as needed (4/17/24) and she would have no complications related to her gastrostomy tube (4/17/24).A current care plan, revised 11/28/23, indicated Resident 12 had the potential for skin integrity impairment related to her gastrostomy tube. Interventions included the following: her care plan will minimize her risk for infection (7/25/23) and treatment as ordered (7/25/23).A current care plan, dated 6/23/23, indicated Resident 12 required assistance with her activities of daily living related to cerebral palsy. Interventions included the following: she had a tube feed and did not consume oral food (6/27/23).During an observation, on 1/22/26 at 3:45 p.m., a magnet indicating EBP hung on the doorframe outside of Resident 12's room. A yellow isolation gown in a plastic bag and a box of gloves hung on the wall beside the door the inside the room. Resident 12 was lying in her bed with the head of bed elevated approximately 30 degrees. Enteral feeding was being administered per her PEG tube. Unit Manager (UM) 18 prepared supplies to perform PEG site care. UM 18 performed hand hygiene and put on gloves. UM 18 informed Resident 12 she was going to clean her PEG site. UM 18 wet the washcloths and sat them on a dry towel on the bedside table. UM 18 searched for soap in nightstand drawer and on top of the nightstand. The soap was placed on the bedside table. UM 18 removed the old gloves and put on a new pair. UM 18 pulled Resident 12's blankets downward, just below the PEG site. UM 18 applied soap to washcloths and washed from insertion site outward. UM 18 used a different edge of wash cloth with each circular motion. A scant amount of tan drainage was observed on the washcloth as she cleansed the site. UM 18 obtained a new washcloth to rinse the soap. A dry towel was used to pat dry the PEG site. UM 18 adjusted Resident 12's clothing and replaced the blankets over Resident 12's abdomen. An isolation gown was not worn by UM 18 during Resident 12's PEG site care. UM 18 indicated isolation gowns were only needed if dealing with the tube feeding and motioned to the IV pole with the tube feeding pump. Gloves were to be worn for incontinence care and personal care. A gown only needed to be worn with PEG site care when PEG site is red, infected, inflamed, had drainage, or if splattering would occur. Staff were expected to wear an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	isolation gown with feeding administration due to the possibility that tube feeding formula could splatter.During an interview, on 1/27/26 12:49 p.m., the DON indicated EBP precautions were to be followed when staff performed personal care, such as emptying catheters and PEG site care. A gown was to be worn when Resident 12's PEG site care was performed. The PEG site was the reason Resident 12 required enhanced barrier precautions.During an interview, on 1/27/26 at 12:53 p.m., the DON indicated the Infection Preventionist (IP) had given her more information and since Resident 12's tube feeding was continuous and the tube feeding was not disconnected during the PEG site care observation, a gown was not needed. During an interview, on 1/27/26 at 12:55 p.m., the DON indicated the information received by the IP was wrong and a gown was needed to be worn for Resident 12's PEG site care.During an interview, on 1/27/25 at 4:45 p.m., the IP indicated she performed rounding to monitor for EBP and infection control. The weekend supervisor assisted with infection control rounding. Training for infection control had been done twice this year already, including EBP. She was not aware that a gown was to be utilized when performing Resident 12's PEG site care. Since the gastrointestinal tract was not sterile, there was no chance of splash and no prolonged contact, she did not feel a gown was needed. She would have done same as UM 18 because the PEG site was old, UM 18 did not stop and remove the feeding, and there was no drainage. During an interview, on 1/27/26 at 4:45 p.m., the Clinical Nurse Consultant indicated the Corporate Clinical Coordinator provided education regarding EBP and hand hygiene in the early Fall of 2025. A facility policy, reviewed/revised on 2/5/25, titled Enhanced Barrier Precaution, provided by the DON on 1/27/26 at 12:55 p.m., indicated the following: Policy: It is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precaution (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.2.b. An order for enhanced barrier precaution will be obtained for residents with any of the following: i.feeding tubes.3. Implementation of Enhanced Barrier Precautions: b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities.4. High-contact resident care activities include: g. Device care or use: feeding tubes.10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.3.1-18(a)