

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

Printed: 06/27/2024  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365162                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                      | (X3) DATE SURVEY<br>COMPLETED<br><br>04/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Wesleyan Village                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>807 West Ave<br>Elyria, OH 44035 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                               |                                                 |
| F 0609<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47990</p> <p>Based on staff interview, record review, policy review, review of the Ohio Department of Health's Certification and Licensure System website, and review of a local police report, the facility failed to ensure an incident of alleged resident-to-resident physical abuse between Resident #99 and Resident #101 was reported. This affected two (Residents #99 and #101) of three residents reviewed for abuse. The facility census was 90.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #99 revealed an admitted [DATE]. Medical diagnoses included delusional disorder, cognitive communication deficit, and atrial fibrillation. Resident #99 was transferred to a local hospital on [DATE] and did not return to the facility.</p> <p>Review of Resident #99's Minimum Data Set (MDS) admission assessment dated [DATE], revealed she had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. Resident #99 was noted to have delusions, verbal behaviors directed towards others on one to three days during the lookback period, and other behavioral symptoms not directed towards others on one to three days during the lookback period.</p> <p>Review of Resident #99's care plan dated [DATE], revealed the resident was known to have behavior problems. Resident #99 was care planned to have hallucinations, delusions and at times was accusatory and felt like others were after her. Care planned interventions included to anticipate and meet the resident's needs and intervene as necessary to protect the rights and safety of others.</p> <p>Review of Resident #99's interdisciplinary progress notes revealed a note dated [DATE] at 9:47 P.M. which stated Resident #99 refused medication and care from staff and was a harm to self, staff, and other residents. Resident #99 was, hitting and grabbing on another resident and as the nurse attempted to intervene, Resident #99 attempted to bite the nurse. The provider was notified and gave an order to send Resident #99 to the hospital for evaluation due to delirium and change of mental status. Notifications were recorded to Resident #99's family and to the receiving hospital.</p> <p>Review of a local police report dated [DATE] at 8:38 P.M. revealed the local police were summoned to the facility due to reports of a resident being highly combative towards staff and other residents.</p> <p>(continued on next page)</p> |                                                                               |                                                 |

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 0609<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>2. Review of the medical record for Resident #101 revealed an admitted [DATE]. Medical diagnoses included metabolic encephalopathy, muscle weakness, dementia, and anxiety. Resident #101 received hospice services while a resident and expired in the facility on [DATE].</p> <p>Review of Resident #101's MDS admission/5-day assessment dated [DATE], revealed the resident had a BIMS score of seven, indicating severely impaired cognition. Resident #101 was not recorded as having any hallucinations, delusions, or behaviors.</p> <p>Review of Resident #101's interdisciplinary progress notes from [DATE] to [DATE] revealed no mention that he had been the recipient of physical contact or aggression by another resident, nor evidence that he had been assessed for injuries following the alleged incident.</p> <p>Review of the Ohio Department of Health's Certification and Licensure System (CALs) website revealed there was no self-reported incident between Resident #99 and Resident #101 from [DATE] to [DATE].</p> <p>An interview on [DATE] at 2:11 P.M. with the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #200 revealed neither had knowledge of an alleged resident-to-resident interaction that occurred on [DATE] with Resident #99 being the aggressor. The DON stated the situation documented in Resident #99's [DATE] progress note was never reported to her and she must have missed it when reviewing documentation. The DON stated this event should have been reported to her, but she was not notified. She verified the event was not reported to the Ohio Department of Health as a self-reported incident, nor investigated, as she did not know about the interaction.</p> <p>An interview on [DATE] at 3:42 P.M. with State tested Nurse Aide (STNA) #210 revealed she worked on the evening of [DATE] and recalled an incident between Resident #99 and Resident #101. STNA #210 stated Resident #99 was the aggressor, and tried to attack Resident #101. Resident #99 grasped her hand onto Resident #101's shoulder when he was in his wheelchair, and pulled him backwards. STNA #210 stated Resident #101's feet were in the air as Resident #99 had tipped him backwards trying to flip him out of his chair. STNA #210 stated Resident #99's behavior was extremely aggressive, to the point she had to be evaluated at the hospital and the police had to come assist in getting Resident #99 to leave with the ambulance.</p> <p>Review of the policy, Abuse, Neglect, Exploitation &amp; Misappropriation of Resident Property, revised [DATE], revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment or misappropriation. Facility staff should immediately report all such allegations to the administrator or designee, and to the Ohio Department of Health. The policy further identified resident-to-resident interactions should be referred to the interdisciplinary team to determine appropriate interventions.</p> <p>This deficiency represents an incidental finding found during the course of the complaint investigation.</p> |                                                                               |                                                 |

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| F 0610<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990</b></p> <p>Based on staff interview, record review, policy review, review of the Ohio Department of Health's Certification and Licensure System website, and review of a local police report, the facility failed to ensure an incident of alleged resident-to-resident physical abuse between Resident #99 and Resident #101 was investigated. This affected two (Residents #99 and #101) of three residents reviewed for abuse. The facility census was 90.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #99 revealed an admitted [DATE]. Medical diagnoses included delusional disorder, cognitive communication deficit, and atrial fibrillation. Resident #99 was transferred to a local hospital on [DATE] and did not return to the facility.</p> <p>Review of Resident #99's Minimum Data Set (MDS) admission assessment dated [DATE], revealed she had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. Resident #99 was noted to have delusions, verbal behaviors directed towards others on one to three days during the lookback period, and other behavioral symptoms not directed towards others on one to three days during the lookback period.</p> <p>Review of Resident #99's care plan dated [DATE], revealed the resident was known to have behavior problems. Resident #99 was care planned to have hallucinations, delusions and at times was accusatory and felt like others were after her. Care planned interventions included to anticipate and meet the resident's needs and intervene as necessary to protect the rights and safety of others.</p> <p>Review of Resident #99's interdisciplinary progress notes revealed a note dated [DATE] at 9:47 P.M. which stated Resident #99 had refused medication and care from staff and was a harm to self, staff, and other residents. Resident #99 was hitting and grabbing on another resident and as the nurse attempted to intervene, Resident #99 attempted to bite the nurse. The provider was notified and gave an order to send Resident #99 to the hospital for evaluation due to delirium and change of mental status. Notifications were recorded to Resident #99's family and to the receiving hospital.</p> <p>Review of a local police report dated [DATE] at 8:38 P.M. revealed the local police were summoned to the facility due to reports of a resident being highly combative towards staff and other residents.</p> <p>2. Review of the medical record for Resident #101 revealed an admitted [DATE]. Medical diagnoses included metabolic encephalopathy, muscle weakness, dementia, and anxiety. Resident #101 received hospice services while a resident and expired in the facility on [DATE].</p> <p>Review of Resident #101's MDS admission/5-day assessment, dated [DATE], revealed the resident had a BIMS score of seven, indicating severely impaired cognition. Resident #101 was not recorded as having any hallucinations, delusions, or behaviors.</p> <p>(continued on next page)</p> |                                                                               |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of Resident #101's interdisciplinary progress notes from [DATE] to [DATE] revealed no mention that he had been the recipient of physical contact or aggression by another resident, nor evidence that he had been assessed for injuries following the alleged incident.</p> <p>Review of the Ohio Department of Health's Certification and Licensure System (CALS) website, there was no self-reported incident between Resident #99 and Resident #101 from [DATE] to [DATE].</p> <p>An interview on [DATE] at 2:11 P.M. with the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #200 revealed neither had knowledge of an alleged resident-to-resident interaction that occurred on [DATE] with Resident #99 being the aggressor. The DON stated the situation documented in Resident #99's [DATE] progress note was never reported to her and she must have missed it when reviewing documentation. The DON stated this event should have been reported to her, but she was not notified. She verified the event was not reported to the Ohio Department of Health as a self-reported incident, nor investigated, as she did not know about the interaction.</p> <p>An interview on [DATE] at 3:42 P.M. with State tested Nurse Aide (STNA) #210 revealed she worked on the evening of [DATE] and recalled an incident between Resident #99 and Resident #101. STNA #210 stated Resident #99 was the aggressor, and tried to attack Resident #101. Resident #99 grasped her hand onto Resident #101's shoulder when he was in his wheelchair, and pulled him backwards. STNA #210 stated Resident #101's feet were in the air as Resident #99 had tipped him backwards trying to flip him out of his chair. STNA #210 stated Resident #99's behavior was extremely aggressive, to the point she had to be evaluated at the hospital and the police had to come assist in getting Resident #99 to leave with the ambulance.</p> <p>Review of the policy, Abuse, Neglect, Exploitation &amp; Misappropriation of Resident Property, dated as revised on [DATE], revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment or misappropriation. Facility staff should immediately report all such allegations to the administrator or designee, and to the Ohio Department of Health. The policy further identified resident-to-resident interactions should be referred to the interdisciplinary team to determine appropriate interventions.</p> <p>This deficiency represents an incidental finding discovered during the course of the complaint investigation.</p> |                                                                               |                                                 |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47990</p> <p>Based on staff and resident interview, record review, and policy review, the facility failed to ensure resident showers were completed as planned. This affected three (Residents #05, #44, and #56) of three residents reviewed for activities of daily living. The facility census was 90.</p> <p>Findings include:</p> <p>1. Review of Resident #05's medical record revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, anxiety, depression, and anemia.</p> <p>Review of Resident #05's Minimum Data Set (MDS) 3.0 annual assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #05 was recorded to require supervision to partial/moderate assistance with activities of daily living (ADL) completion. Resident #05 was not identified as having any behaviors or rejection of care.</p> <p>Review of Resident #05's physician's order dated 03/15/24, revealed the resident was supposed to receive a shower twice weekly on Wednesday and Saturday on night shift.</p> <p>Review of facility shower records from 03/15/24 to 04/15/24 revealed the facility only provided showers on 03/30/24, 04/04/24, and 04/15/24.</p> <p>An interview on 04/15/24 at 9:51 A.M. revealed Resident #05 stated she was supposed to get showers twice weekly but stated she was lucky if she got one shower a week.</p> <p>2. Review of Resident #44's medical record revealed an admitted [DATE]. Medical diagnoses included muscular dystrophy, morbid obesity, bed confinement status, and depression.</p> <p>Review of Resident #44's MDS 3.0 annual assessment, dated 02/14/24, revealed the resident had a BIMS score of 15, indicating intact cognition. Resident #44 was recorded to be substantial/maximum assistance to dependent for ADL completion. Resident #44 was not identified as having any behaviors or rejection of care.</p> <p>Review of Resident #44's physician order dated 07/23/23, revealed the resident was supposed to receive a shower twice weekly on Monday and Thursday evenings.</p> <p>Review of facility shower records from 03/15/24 to 04/15/24 revealed the facility only provided showers on 03/25/24, 04/08/24, and 04/11/24.</p> <p>An interview on 04/11/24 at 8:07 A.M. with Resident #44 revealed she prefers bed baths on her shower days. Resident #44 stated she knows she is supposed to get a full bed bath and linen change twice weekly but it rarely happens.</p> <p>(continued on next page)</p> |                                                                               |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365162                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                      | (X3) DATE SURVEY<br>COMPLETED<br><br>04/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Wesleyan Village                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>807 West Ave<br>Elyria, OH 44035 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                               |                                                 |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>3. Review of Resident #56's medical record revealed an admitted [DATE]. Medical diagnoses included congestive heart failure, morbid obesity, type II diabetes mellitus, and chronic obstructive pulmonary disease.</p> <p>Review of Resident #56's MDS 3.0 quarterly assessment, dated 03/13/24, revealed the resident had a BIMS score of 11, indicating moderately impaired cognition. Resident #56 was recorded to be substantial/maximum assistance to dependent for ADL completion. Resident #56 was not identified as having any behaviors, including refusal or rejection of care.</p> <p>Review of Resident #56's physician order dated 07/06/23, revealed the resident was supposed to receive a shower twice weekly on Monday and Thursday nights.</p> <p>Review of facility shower records from 03/15/24 to 04/15/24 revealed the facility only provided showers to Resident #56 on 03/18/24 and 04/08/24.</p> <p>An interview on 04/15/24 at 10:11 A.M. with Resident #56 revealed she rarely gets a shower. Resident #56 was unable to recall when her last shower was but did not think it was recent.</p> <p>An interview on 04/15/24 at 12:19 P.M. with the Director of Nursing (DON) revealed she could only find a few shower sheets for each resident. The DON stated she was unsure where the remaining shower sheets were, or if they had even been completed. The DON verified the provided shower sheets did not reflect evidence that Resident #05, Resident #44, and Resident #56 had received their regularly scheduled showers twice weekly.</p> <p>A follow up interview on 04/15/24 at 2:11 P.M. with the Regional Director of Clinical Services (RCDS) #200 verified all the shower sheets were provided for the three sampled residents and there were no additional shower sheets completed. RCDS #200 stated she checked the electronic documentation and also did not find evidence the three sampled residents had received their planned showers.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00152961.</p> |                                                                               |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365162                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                      | (X3) DATE SURVEY<br>COMPLETED<br><br>04/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Wesleyan Village                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>807 West Ave<br>Elyria, OH 44035 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                               |                                                 |
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| F 0806<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47990</p> <p>Based on observation, staff and resident interview, and record review, the facility failed to ensure Resident #48 was served her physician-ordered diet which accommodated her dietary restrictions. This affected one (Resident #48) of three residents reviewed for dietary services. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #48 revealed an admitted [DATE]. Medical diagnoses included end stage renal disease (ESRD) with dependence on renal dialysis, muscle weakness, type II diabetes mellitus, and muscle weakness. The record indicated Resident #48 was lactose intolerant. Resident #48 was hospitalized on [DATE] and readmitted to the facility on [DATE].</p> <p>Review of Resident #48's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition.</p> <p>Review of Resident #48's interdisciplinary progress notes revealed a note dated 03/16/24 indicating ranch and blue cheese salad dressings were taken out of Resident #48's room per the resident's request due to dairy intolerance. The note indicated Resident #48 had been vomiting due to eating dairy in the afternoon.</p> <p>Review of Resident #48's hospital records dated 03/21/24, summarizing her 03/16/24 to 03/21/24 hospital stay, revealed the resident was initially sent to the hospital on 03/16/24 for vomiting, with the cause attributed to having received ranch dressing on her salad as she is lactose intolerant. The records indicated that after eating the ranch dressing, Resident #48 had persistent vomiting and multiple episodes of diarrhea over the few days leading up to the hospital transfer.</p> <p>Review of Resident #48's physician-ordered diet dated 03/22/24, for a liberalized renal, reduced concentrated sweets diet with regular texture and thin liquids. Specific instructions in the order detail indicated Resident #48 was on a fluid restriction of 1200 milliliters (ml) of fluid daily, was lactose intolerant, and preferred soy milk. The diet order additionally stated Resident #48 was to have no cheese, no regular milk, no bananas, no ice cream, no potatoes, no orange juice, no tomatoes, and no oranges.</p> <p>Review of the posted daily menu on 04/10/24 revealed the lunch meal was planned to be cheese ravioli, broccoli and a breadstick. The soup of the day posted outside the kitchen was potato soup.</p> <p>(continued on next page)</p> |                                                                               |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365162                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                      | (X3) DATE SURVEY<br>COMPLETED<br><br>04/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Wesleyan Village                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>807 West Ave<br>Elyria, OH 44035 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                               |                                                 |
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| F 0806<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>An observation and interview on 04/10/24 at 12:14 P.M. revealed Resident #48 had her partially eaten meal tray in front of her. Present on the tray included cheese ravioli with cream sauce, a bowl of potato soup, and a packet of ranch dressing which stated on the package contained milk and egg. An uneaten banana was present on Resident #48's overbed table. Resident #48 verified she was lactose intolerant and stated she had asked numerous times in the past to receive food items in line with her dietary restrictions and allergies, but they were never honored. Resident #48 stated she received the banana for breakfast this morning, and is tired of having to decide between eating food items that make her ill or going hungry. A tray ticket specifying Resident #48 was to have no cheese, dairy, potatoes, and bananas, among other items, was present on Resident #48's meal tray.</p> <p>An interview on 04/10/24 at 12:20 P.M. with Dietary Manager #32 in Resident #48's room verified the tray provided to the resident did not meet the resident's physician-ordered dietary and allergy restrictions. DM #32 verified the tray ticket present on the resident's tray was correct, but the staff must not have read it, looked at it, or understood it. DM #32 verified they should not be providing Resident #48 with a banana, potatoes, or dairy products.</p> <p>Review of the policy titled, Therapeutic Diets, revised November 2015, revealed therapeutic diets include diets modified for medical or nutritional needs. Therapeutic diets will be determined in accordance with the resident's informed choices, preferences, treatment goals, and wishes and must be ordered by the resident's attending physician. The physician's diet order should match the terminology used by food services.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152235.</p> |                                                                               |                                                 |