

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Wesleyan Village		STREET ADDRESS, CITY, STATE, ZIP CODE 807 West Ave 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, medical record review, resident interview and staff interview, the facility failed to ensure resident rooms were adequately maintained. This affected one (#67) of three residents reviewed for safe and homelike environment. Additionally, the facility failed to ensure common areas, accessible to residents, was free from mold. This had the potential to affect three (#49, #75 and #86) of three male residents identified by the facility as being independent with mobility and toileting. The facility census was 86. Findings include: 1. Record review for Resident #67 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 had a Brief Interview of Mental Status (BIMS) score of 12, indicating the resident was moderately cognitively impaired. Resident #67 had no impairment of the upper or lower extremities, used a walker and or a wheelchair for mobility and the resident was independent with toileting. Observation 06/12/24 at 9:51 A.M. of Resident #67's room revealed she had two double slide windows in her room. The double slide window on the right side of her room had a broken handle that prevented the window from opening. The double slide window on the left side of the room had a piece of wood covering the right window pane, which prevented the window from opening. Concurrent interview with Resident #67 revealed the windows in her room had been that way since her admission. Resident #67 revealed she would like to crack the windows open at times to get fresh air but was unable. Continued observation of Resident #67's bathroom revealed the toilet handle in Resident #67's room was broken in the center of the handle, separating the handle and creating sharp edges at the separation point. Additionally, the light fixture above the bathroom mirror did not initially come on when the resident flipped the switch to turn it on. After approximately 90 seconds, the light turned on and blinked continuously. Resident #67 stated that's what it does. Resident #67 confirmed she used the bathroom and had to be careful not to cut herself on the toilet handle when she flushed it. Interview on 06/12/24 at 9:58 A.M. with Housekeeper #910 verified the findings in Resident #67's room and bathroom. Housekeeper #910 stated it had been that way for a year or two and maintenance was aware. Housekeeper #910 stated the facility only had one maintenance staff for approximately six months, but now there was a second maintenance staff. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Observation on 06/12/24 at 9:36 A.M. of the men's bathroom, located in the main lobby, revealed in stall #1 a large portion of wallpaper was separated at the seam and curled back, exposing black mold like substance on the exposed wallpaper and drywall. Continued observation revealed a black mold like substance covering the lower corner molding behind the toilet. Interview on 06/12/24 at 9:44 A.M. with Maintenance Director (MD) #540 and Maintenance #475 confirmed the substance stall #1 of the men's bathroom in the main lobby was mold. MD #540 and Maintenance #475 confirmed the bathroom was a public restroom used by residents and visitors. This deficiency represents non-compliance investigated under Complaint Number OH00154916, OH00154761, OH00153713, and OH00153215.		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, review of medical records, review of facility self-reported incidents (SRI), interviews with staff, interview with family, interview with the Wound Care Certified Nurse Practitioner (WCCNP), interview with the Medical Director (MD), review of timecard punches and review of the facility policy, the facility failed to ensure residents were free from staff-to-resident physical and verbal abuse. This resulted in Immediate Jeopardy and the potential for serious injuries, negative health outcomes, and/or psychosocial harm when on 05/19/24 at approximately 5:30 P.M., the facility failed to recognize and appropriately respond to an allegation of staff-to-resident abuse when Registered Nurse (RN) #500 was witnessed by State tested Nursing Assistant (STNA) #465 and STNA #501 swearing and yelling at Resident #19. RN #500 removed Resident #19 from the dining room, took the resident to her room, slammed the door and remained alone in the room with Resident #19 for approximately 10 to 15 minutes. During this time, STNA #465 and STNA #501 heard RN #500 yelling and swearing at the resident and heard Resident #19 crying louder. No staff intervention occurred to protect the safety of Resident #19. After RN #500 exited Resident #19's room, the resident was found by STNA #501 to be crying and holding up her arms, which had blood spots on the Geri sleeves she was wearing, and a bruise on her hand. Resident #19 had a total of nine wounds confirmed and measured by WCCNP #502. The facility failed to incorporate effective interventions to prevent further abuse from occurring when RN #500 was permitted to return to work with Resident #19, unsupervised, on 05/27/24. Additionally, a reasonable person in Resident #19's position would potentially have experienced severe psychosocial harm from the verbal and physical abuse/assault. This affected one (#19) of three residents reviewed for abuse. The facility census was 86. On 06/06/24 at 11:35 A.M., the Administrator, Regional Director of Operations (RDO) #503, and Regional Director of Clinical Services (RDCS) #510 were notified Immediate Jeopardy began on 05/19/24 at approximately 5:30 P.M. when Resident #19, a cognitively impaired resident residing on the memory care unit, was removed from the dining room by RN #500 who expressed frustration with the resident. RN #500 took Resident #19 to her room, slammed the door and RN #500 remained in the room with Resident #19 for approximately 10 to 15 minutes. During that time, STNA #465 and STNA #501 reported Resident #19 was heard screaming. RN #500 exited the room and STNA #501 entered and found Resident #19 crying, with blood noted on the Geri sleeves on her arms and bruising on her hand. STNA #501 got RN #500 to assess the injuries noted to Resident #19. STNA #501 reported RN #500 stated Wow. She is something else. She tried to get me, and we got into it. Resident #19 was subsequently seen on 05/22/24 by wound care for a total of nine identified wounds as a result of the incident on 05/19/24. The Immediate Jeopardy was removed on 06/07/24 when the facility implemented the following corrective actions: On 05/19/24 at 9:40 P.M., RN #521 notified Resident #19's daughter/Power of Attorney (POA) of new skin tears and bruising to the resident's arms. On 05/19/24 at 9:45 P.M., RN #521 notified Assistant Director of Nursing (ADON) # 522 Resident #19 had skin tears and bruising to bilateral arms. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/19/24 at 10:00 P.M., ADON #522 notified the Administrator of the skin tears and bilateral bruising to the arms on Resident #19. On 05/19/24 at 10:03 P.M., the Administrator notified RDCS #510 of Resident #19's skin tears and bilateral bruising to the arms. On 05/19/24 at 10:05 P.M., the Administrator notified RDO #503 of Resident #19's injuries. On 05/19/24 at 10:21 P.M., the Administrator opened an SRI for an injury of unknown origin. On 05/19/24 at 10:30 P.M., the Administrator interviewed RN #521, via phone, regarding Resident #19's injuries. Per RN #521, STNA #465 and STNA #501 reported Resident #19 had bruising and blood on her Geri sleeves. RN #521 cleansed the resident 's arms with normal saline (NS), applied Steri-Strips and xeroform dressing and wrapped the resident 's arms in kerlix. RN #521 performed a skin assessment on Resident #19. On 05/19/24 at 10:57 P.M., RN #521 notified CNP #524 of Resident #19's new skin tears and bilateral bruising to arms. New orders were obtained for bilateral x-rays of hands and arms. On 05/20/24 at 9:00 A.M., the Director of Nursing (DON) interviewed RN #500, via phone, due to staff report of RN #500 feeling frustrated with Resident #19 on the night of the incident. RN #500 stated she took Resident #19 to her room, around dinner time, for approximately 10 minutes. RN #500 was suspended pending the outcome of the investigation. On 05/20/24, Assistant Administrator (AA) #523 interviewed 12 random staff; STNA #602, STNA #627, STNA #609, STNA #620, STNA #515, STNA #631, STNA #671, STNA #673, STNA #675, STNA #676, STNA #619, and Licensed Practical Nurse (LPN) #632 regarding witnessing abuse or reporting abuse, with no findings. On 05/20/24 beginning at 10:00 A.M. and completed on 05/24/24 at 8:30 P.M., ADON #522 initiated Residents Rights and Abuse Inservice for all staff. This was completed in person and via phone. On 05/20/24 at 2:00 P.M., Resident #19 was seen by CNP #524. New orders were received for oxycodone for pain from skin tears and bruising and Keflex (antibiotic) for prevention of infection from skin tears. On 05/20/24 at 3:00 P.M., CNP #524 ordered Resident #19 's assist rails be removed from the resident 's bed to reduce risk of injury. The assist rails were removed from Resident #19's bed at 3:30 P.M. On 05/21/24 at 7:00 A.M., laboratory (lab) orders, which included a Complete Blood Count (CBC) with differential, was completed for Resident #19. On 05/21/24 at 12:30 P.M., Resident #19's lab results were received and reported to the physician. No new orders were received. On 05/21/24 at 1:30 P.M., the Administrator and DON re-interviewed RN #500. No additional information was obtained. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/21/24 at 4:27 P.M., an x-ray was completed for Resident #19's bilateral arms and hands. On 05/22/24 at 8:00 A.M., Resident #19 was evaluated by WCCNP #502 for skin tears to bilateral arms. On 05/22/24 from 10:30 A.M. until 11:30 A.M., ADON #522 interviewed alert residents on the memory care unit regarding abuse reporting, witnessing abuse and ensured residents felt safe with no negative findings. On 05/22/24 from 2:00 P.M. to 4:45 P.M., ADON #522 completed skin assessments of all residents on the memory care unit with no negative findings. On 05/22/24 at 3:00 P.M., Resident #19 was evaluated by Medical Director (MD) #750. No bruising was noted to the resident ' s face at the time of the examination. A new order was received for referral to hematology. An appointment was scheduled for 05/30/24. On 05/23/24 at 1:00 P.M., x-ray results of bilateral arms and hands received for Resident #19 with no fractures identified. On 05/24/24 at 7:21 P.M., the SRI for injury of unknown origin was closed with an unsubstantiated finding. No abuse concerns were identified. On 05/27/24 at 1:42 P.M., the DON informed RN #500 Resident #19's family requested, due to the incident on 05/19/24, she no longer work with the resident. RN #500 was offered the option to work on another unit. RN #500 refused the reassignment and immediately terminated her employment at the facility. On 05/29/24 at 10:10 A.M., Resident #19 was seen by psychiatric services, Psychiatric CNP (PCNP) #700, with no negative findings. On 05/30/24 at 8:00 A.M., Resident #19 was evaluated by hematology and no new orders were received. On 06/06/24 at 11:50 A.M., the Administrator, RDCS #510 and RDO #503 interviewed MD #750 regarding potential causes of Resident #19 ' s injuries on 05/19/24. MD #750 indicated it was possible to sustain ecchymosis (bruising) with normal handling. On 06/06/24 at 12:00 P.M., the Administrator, RDCS #510 and RDO #503 completed a root cause analysis and determined a thorough investigation was not completed related to the incident involving RN #500 and Resident #19 on 05/19/24 and abuse likely occurred. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/06/24 at 12:15 P.M., an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator to review the Immediate Jeopardy findings and reviewed prevention of resident abuse and facility policies related to prevention, identification and investigation of allegations of resident abuse. The QAPI meeting was attended by the Administrator, RDO #503, RDCS #510, Transportation Director (TD) #525, Activities Director Assisted Living (ADAL) #526, Activities Director (AD) #900, Housekeeping and Laundry Director (HLD) #527, Medical Records Clerk (MRC) #528, Chaplin #529, Central Supply (CS) #530, Marketing Director #531, Scheduler #515, Human Resources Director (HRD) #520, Minimum Data Set Coordinator (MDSC) #532, Business Office Manager (BOM) #533, Admissions/Social Services Designee (SSD) #535, Assistant Administrator (AA) #523, and Director of Maintenance (DOM) #540. On 06/06/24 at 12:30 P.M., RDO #503 and RDCS #510 re-educated all department heads, including the Administrator and DON, on the facility ' s abuse policy and prevention, reporting and investigation of allegations of abuse. Additionally, education was provided related to SRI reporting categories. On 06/06/24 at 2:35 P.M., the Administrator filed a report with the Ohio Board of Nursing related to suspected resident abuse on 05/19/24 involving RN #500. On 06/06/24 at 2:45 P.M., the Administrator filed a police report with the local police department related to suspected staff-to-resident abuse on 05/19/24. On 06/06/24 from 8:00 P.M. through 9:30 P.M., department heads re-educated all staff on the facility's Abuse Policy, Abuse Prevention Policy and Abuse Investigation Policy. Staff who could not be reached for their education were left a voicemail message indicating they could not return to work until they received the education. Interviews on 06/06/24 from 8:12 P.M. through 8:15 P.M. with STNA #671, STNA #609 and RN #521 verified each had received education on the facility's abuse prevention and reporting policies and procedures. On 06/06/24 from 9:00 P.M. through 11:35 P.M., AA #523 completed interviews with all staff who worked on 05/17/24, 05/18/24 and 05/19/24, including STNA #465, STNA #600, STNA #501, STNA #601, STNA #602, STNA #603, STNA #604, STNA #605, STNA #606, STNA #607, STNA #608, STNA #609, STNA #470 and STNA #611, LPN #612, LPN #613, LPN #614, LPN #615 and LPN #616, RN #617 and RN #521, AD # 500, Occupational Therapist (OT) #618, MRC #528, CS #530, Marketing Director #531, TD # 525, HRD #520, DOM #540 and SSD #535. Voicemail messages were left for those staff who could not be reached, including STNA #619, STNA #620, STNA #621, STNA #622, STNA #623, STNA #624, STNA #625, STNA #626, STNA #627, STNA #628, STNA #629, STNA #630, STNA #631 and LPN #632, LPN #633 and LPN #634 to complete interviews. No new information or areas of concern were identified in the staff interviews. On 06/06/24 at 9:35 P.M., RDCS #510, RDO #503 and the Administrator interviewed WCCNP #502 regarding Resident #19's injuries. On 06/06/24 from 10:00 P.M. through 11:30 P.M., the DON and ADON #522 completed skin audits on all residents. No negative findings were identified. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 06/06/24, the Administrator will review all potential SRIs with [NAME] President of Operations (VPO) #640 and [NAME] President of Clinical Services (VPCS) #641 to ensure the appropriate SRI category is filed and thoroughly investigated. Beginning on 06/06/24, the Administrator, or designee will ensure written staff statements are validated for authenticity by reviewing the statement with the reporting staff. The statement will be signed by the reporting staff and counter signed by the Administrator or designee. Beginning on 06/06/24, VPO #640 and VPCS #641 will audit each initial SRI prior to submission to ensure the facility files incidents under the correct investigation category for four weeks. Beginning on 06/06/24, RDO #503, RDCS #510 or designee will audit every SRI submitted for four weeks, then as needed, to ensure a thorough investigation was completed. Beginning on 06/06/24, the Administrator or designee will conduct 10 random resident interviews with alert residents to ensure residents are free from abuse for four weeks, then as needed. Beginning on 06/06/24, the DON or designee will conduct 10 random skin assessments weekly for four weeks, then monthly thereafter, on non-interviewable residents to ensure residents are free from abuse. Beginning on 06/07/24, SSD #535 will meet with Resident #19 three times weekly for four weeks to assess psychosocial well-being and provide additional support. Results of audits will be reviewed at the QAPI meeting weekly for four weeks, then monthly thereafter to determine on-going compliance. Review of two (#34 and #62) additional open resident records revealed no concerns related to resident abuse. Although the Immediate Jeopardy was removed on 06/07/24, the facility remained out of compliance at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Record review for Resident #19 revealed an admitted [DATE]. Diagnoses included neurocognitive disorder with Lewy Bodies, Parkinson's disease, dementia, anxiety disorder and Pseudobulbar affect (a medical condition that causes sudden and uncontrollable crying and or laughing). Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/17/24, revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating Resident #19 was severely cognitively impaired. Resident #19 used a wheelchair for mobility, required assistance with activities of daily living (ADLs) and the resident had no skin tears. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the care plan, dated 04/17/24, revealed Resident #19 had a behavior problem related to crying and yelling. Interventions included to anticipate and meet the needs of the resident and caregivers to provide opportunities for positive interactions, attention, and speak in a calm manner. Review of the Weekly Skin Assessments from 04/01/24 through 05/18/24 for Resident #19 revealed two weekly skin assessments were documented, one on 04/19/24 at 6:45 A.M. completed by LPN #702 and one on 05/03/24 at 6:18 A.M. completed by LPN #703. Each assessment revealed Resident #19 had no bruises, skin tears, lesions, cuts or abrasions noted. Review of the nursing progress notes from 04/01/24 through 05/18/24 revealed no documentation of incidents of bruises, skin tears, lesions, cuts or abrasions for Resident #19. Review of the shower sheets for Resident #19, dated 03/02/24, 03/06/24, 03/08/24, 03/13/24, 03/23/24, 04/27/24, 05/01/24, 05/04/24, 05/08/24, 05/11/24 and 05/15/24 revealed no skin tears or bruising to the arms or face. Review of a nursing progress note, dated 05/19/24 at 10:11 P.M. completed by RN #521, revealed the STNA reported Resident #19 developed skin tears during the day. RN #521 went into the room and observed the resident had multiple skin tears to bilateral upper extremities and new bruising to both hands. The skin tears were cleansed with normal saline, skin folded back over with Steri-Strips and a xerofoam dressing was applied and wrapped in kerlix. ADON #522 was updated, and the daughter was notified. A message was left for the on-call physician for MD #750, awaiting response. Review of a nursing progress note, dated 05/19/24 at 10:53 P.M. completed by RN #521, revealed Resident #19 had kerlix wrapped on her upper extremities before RN #521 cleansed the skin tears and rewrapped. RN #521 asked the STNA if Resident #19 had been wearing Geri sleeves during the day and the STNA confirmed Resident #19 had been wearing them. Review of the facility SRI revealed an injury of unknown origin was initiated by the Administrator for Resident #19, with a date of discovery of 05/19/24. Resident #19 complained of pain and the nurse medicated the resident. The nurse received report from staff that the resident was found with bruises and skin tears on bilateral arms. Resident #19 had a history of removing Geri sleeves and picking at skin. Staff became aware of the injuries on 05/19/24 at 9:45 P.M. The Administrator was notified at 10:00 P.M. by ADON #522, aids reported to the nurse and no other agencies were notified. Interventions included Geri sleeves were discontinued due to resident removing them causing injury. Review of the physician orders dated 05/20/24 revealed Resident #19 was ordered oxycodone oral tablet five milligrams (mg), give 2.5 mg by mouth every six hours as needed for moderate pain and Keflex oral capsule 250 mg give one tablet by mouth every six hours for seven days. Review of the Medication Administration Record (MAR) for Resident #19 for May 2024 revealed Resident #19 used the oxycodone oral tablet five mg tablet 11 times from 05/21/24 through 05/29/24 for pain. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 06/03/24 at 1:50 P.M. of Resident #19 revealed the resident was sitting in a wheelchair in her room. Resident #19 was calm and did not respond to questions asked by the surveyor. Resident #19 had bilateral Geri sleeves on, and a visible dressing was located on the right hand, partially covered by the Geri sleeve. The left side of Resident #19 's face had three small red areas in a vertical line on the outer portion of her cheek. Resident #19 had a visitor who introduced herself as a sitter. Resident #19 's daughter called the sitter on the phone and inquired who was in the room. Concurrent interview with Resident #19 's daughter revealed she had a camera placed in the resident 's room because Resident #19 was hurt by someone at the facility and received skin tears down her arms, a bruise to her right cheek and blood spots to the other side of her face. Resident #19's daughter revealed on 05/19/24 she received a phone call from RN #521, who stated two staff members reported there was an incident. Resident #19's daughter stated it was a nurse who caused the resident 's injuries and she subsequently quit after being offered assignment on another floor and refused. Interview on 06/03/24 at 1:57 P.M. with STNA #607 revealed she worked on first shift (6:30 A.M. until 3:00 P. M.) on 05/19/24 with Resident #19. STNA #607 stated Resident #19 did not have any bruises or skin tears anywhere during her shift. STNA #607 revealed RN #500 was the nurse that shift, and Resident #19 was a two person assist for care. STNA #607 stated she heard RN #500 took Resident #19 to her room by herself and slammed the door. When the door opened Resident #19 had a bruised face with multiple markings, one on her chest, and multiple open areas to her arms. The family placed a camera in the resident 's room after that. STNA #607 stated when Resident #19 was taken to her room, she was not beaten up, but when she came out, she was. STNA #607 stated Resident #19 was not able to tell anyone anything that happened. Additionally, STNA #607 stated on 05/22/24, AA #523 asked her questions about Resident #19, such as how she transferred and changed. STNA #607 stated she asked AA #523 why they called her in about the incident on 05/19/24 with Resident #19 when they did not talk to the two STNAs who were working. Interview on 06/03/24 at 4:49 P.M. and 06/04/24 at 4:42 P.M. with the DON confirmed the bruises on Resident #19's face were not mentioned in the SRI or in the nursing notes completed 05/19/24. The DON stated the bruises showed up a few days later and she did not know how Resident #19 got them because she did not investigate the cause. The DON revealed she concluded Resident #19 caused the bruises to her face and the skin tears to her arms herself from picking at the Geri sleeves. The DON confirmed there was no documentation in Resident #19's medical record from 04/01/24 through 05/19/24 of any picking at her Geri sleeves, causing self-inflicted skin tears or bruises. The DON stated Resident #19 had a low blood count, which could have caused the wounds. The DON confirmed Resident #19 received antibiotics (Keflex) for seven days to prevent an infection from the skin tears. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/04/24 at 2:53 P.M. with STNA #465 revealed on 05/19/24 she started her shift at 6:30 A.M. and worked until 11:00 P.M. STNA #465 stated when she started her shift, Resident #19 had no skin tears or bruising. Resident #19 frequently cried her usual cry, which was normal for her. STNA #465 stated it was more of a weeping, with no tears, than an actual cry. STNA #465 stated RN #500 was frustrated with Resident #19 throughout the day and RN #500 was frustrated a lot with Resident #19 because of her whining. STNA #465 revealed she heard RN #500 tell Resident #19 to shut up (using profanity) and telling the resident she was so annoying. STNA #465 revealed she reported in the past to the DON that RN #500 would get angry, sear at, and tell Resident #19 to shut up but she was unaware of the DON following up on this. STNA #465 reported on 05/19/24, RN #500 was swearing at Resident #19 and around dinner time, approximately 5:30 P.M., RN #500 removed the resident from the dining room and states she could not take her whining anymore. STNA #465 stated RN #500 took Resident #19 to her room, slammed the door and then she heard the resident screaming louder and RN #500 was screaming at her to shut up, again using profanity towards Resident #19. STNA #465 stated prior to Resident #19 going in the room alone with RN #500, Resident #19 had no injuries to her arms. While Resident #19 had a history of picking her skin, STNA #465 denied the resident ever caused injuries like those she had after RN #500 left the resident 's room, noting the wounds were horrible. STNA #465 stated while RN #500 was in the room with Resident #19, the resident was screaming a terrified scream. After about 10 to 15 minutes RN #500 exited the resident 's room and Resident #19 remained in her room. STNA #465 stated STNA #501 went into Resident #19's room and called her to come to into the room to see Resident #19. STNA #465 stated Resident #19 was reaching out and crying real tears, saying look, look and pointing to her Geri sleeves. STNA #465 revealed Resident #19 's Geri sleeves were bloody. STNA #465 stated STNA #501 went to get RN #500 and they both went back into Resident #19 's room together. RN #500 wrapped Resident #19 's arms, but STNA #465 stated not very well. STNA #465 stated RN #500 came out of Resident #19's room and stated the resident had three new skin tears because they got into it and referred to Resident #19 in a derogatory manner. STNA #465 revealed Resident #19's face was red at the time and the bruises appeared the next morning. RN #521 came in at 6:30 P.M. and both STNA #465 and #501 told him he needed to look at Resident #19 because it was bad. RN #521 removed the bandages placed by RN #500 and reported it. STNA #465 confirmed she wrote a statement with all this information on 05/19/24, but no one ever interviewed her about the incident. Interview on 06/04/24 at 3:13 P.M. with STNA #501 revealed she started her shift at 2:30 P.M. on 05/19/24. Resident #19 was her assigned resident. STNA #501 revealed Resident #19 would make whining noises on and off daily, but never had tears. STNA #501 stated Resident #19 had no skin tears, bleeding, or bruising at the beginning of her shift on 05/19/24. Around dinner time, Resident #19 was in the dining room making whining noises. RN #500 was yelling this is enough and took Resident #19 to her room. STNA #501 stated she heard Resident #19 's door slam, with RN #500 remaining alone in the room with the resident. STNA #501 stated she heard Resident #19 screaming very loud and crying louder and louder. STNA #501 stated after RN #500 exited the resident 's room she entered and found Resident #19 crying real tears, there was blood on her Geri sleeves and upper arms and bruising on her hand. STNA #501 stated she went to get RN #500 who stated Resident #19 was something else, she tried to get me, and we got into it. STNA #501 stated Resident #19 had a history of picking her skin, but she had never seen the resident cause wounds like those she had that day. STNA #501 stated when RN #521 came in for his shift, she reported the incident to him. Interview on 06/04/24 at 4:23 P.M. with the Administrator confirmed a police report was never made regarding the allegation made on 05/19/24 between RN #500 and Resident #19. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/05/24 at 10:52 A.M. with WCCNP #502 revealed she visited residents at the facility weekly for wound assessment. WCCNP #502 revealed she had never visited Resident #19 prior to 05/22/24 and noted the resident had multiple skin tears during her assessment on 05/22/24. WCCNP #502 revealed bruising could occur easier with contact if the person had a low blood count and low platelets; however, WCCNP #502 confirmed Resident #19 's skin tears and abrasions were not consistent with low hemoglobin, and they were not consistent with self-picking. WCCNP #502 stated staff indicated Resident #19 could be combative, but the resident was not anxious during her examination. WCCNP #502 stated Resident #19 had no evidence of fingernail scratches, which would likely be seen if someone is self-picking their skin. Additionally, WCCNP #502 stated Steri-Strips were needed to reapproximate the skin flaps, also not consistent with skin picking. WCCNP #502 stated she did not believe Resident #19 's wounds were the result of skin picking or low hemoglobin levels. At the time of her examination, WCCNP #502 asked the nurse what happened, who stated she was unsure, but WCCNP #502 stated she wanted to get to the bottom of how Resident #19 sustained the wounds because they were bad. Lastly, WCCNP #502 stated all of the wounds happened at the same time, it was not a here and there and it was all one incident. Interview on 06/05/24 at 12:27 P.M. with the DON revealed RN #500 returned to work on Resident #19's unit on 05/27/24. RN #500 was the only nurse that shift for that unit. The DON stated she told RN #500 she had to move to another floor because Resident #19's daughter did not want her caring for Resident #19. The DON revealed RN #500 became very upset and said she should not have to move, she opted to go home, said she wasn ' t feeling well and said she would not be back. The DON stated RN #500 resigned and did not return to work at the facility. Review of the facility investigation revealed a witness statement, typed and dated 05/20/24 signed by the DON, revealed a telephone interview was conducted with RN #500. RN #500 stated she went to administer medications to Resident #19. Upon entering the room, Resident #19 was already agitated and aggressive. The resident started to hit, kick and spit. RN #500 went to administer the medications with a spoon when Resident #19 grabbed her arm, pulling it towards her mouth with strong force. RN #500 further stated when she attempted to pull her arm back from the resident, she proceeded to use more force and grabbed her arm, pulling it to her face. RN #500 stated she placed her other hand on the resident ' s hand and pulled it away gently. RN #500 stated she was not successful in administering medications, walked away and chose to reapproach later, when calm. Review of a handwritten witness statement, dated 05/21/24 and signed with an illegible signature, revealed RN #500 stated Resident #19 had been crying and combative all day and the aides let her stay in bed. Resident #19 was provided breakfast in her room, which staff would do if the resident was being combative. RN #500 stated she attempted to give the resident medications at dinner time and the resident started kicking, hitting and spitting the medications out. RN #500 stated she took Resident #19 back to her room to do treatment on skin tears to her arms. RN #500 states she did the best she could due to Resident #19 being combative and the resident picked at her skin and made her arms bleed. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 06/05/24 at 12:51 P.M. with RN #500 revealed she terminated employment at the facility because they said, I beat up Resident #19. RN #500 stated she was suspended then allowed to return to work. However, on the day she returned to work, RN #500 was told she would have to work on another floor, so she quit. On 05/19/24, RN #500 stated Resident #19 was very combative, attempting to hit, claw, and spit in her face. RN #500 stated Resident #19 was sitting in a wheelchair in her room trying to hurt her. RN #500 stated she entered the resident's room and attempted to give her medication. The resident was already aggressive. RN #500 stated the resident hit her arm. She was able to give a little medication to the resident, who then spit it in RN #500 ' s face. RN #500 stated she left Resident #19's room. RN #500 stated she could not recall if the door was closed to Resident #19 ' s room and stated the resident already had skin tears, she had just reopened t[TRUNCATED]		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, review of self-reported incidents (SRI), interviews with staff, interview with the Medical Director (MD), interview with the Wound Care Nurse Practitioner (WCCNP), review of staff schedules, review of the facility investigation and review of the facility policy, the facility failed to ensure an allegation of staff-to-resident abuse was accurately reported and thoroughly investigated to protect residents from further potential abuse. This resulted in Immediate Jeopardy and the potential for serious injuries, negative health outcomes, and/or psychosocial harm when on 05/19/24 at approximately 10:21 P.M. the Administrator filed an SRI for an injury of unknown origin after State tested Nursing Assistant (STNA) #465 and STNA #501 alleged verbal and physical abuse of Resident #19 by Registered Nurse (RN) #500. Resident #19 sustained nine separate wounds as a result of the incident. The facility failed to accurately file an SRI, failed to interview staff witnesses (STNA #465 and STNA #501) and medical providers regarding the potential cause of Resident #19 ' s injuries, failed to validate staff witness statements, failed to file a police report and failed to notify the Ohio Board of Nursing of suspected staff-to-resident abuse. Furthermore, without thoroughly investigating the allegation, the facility permitted RN #500 to return to work with Resident #19, unsupervised, on 05/27/24. RN #500 subsequently terminated her employment with the facility after Resident #19's family requested she no longer work with the resident. This affected one (#19) of four residents reviewed for abuse investigations. The facility census was 86. On 06/06/24 at 11:35 A.M., the Administrator, Regional Director of Operations (RDO) #503, and Regional Director of Clinical Services (RDCS) #510 were notified Immediate Jeopardy began on 05/19/24 at 10:21 P. M. when the Administrator initiated an SRI for an injury of unknown origin for Resident #19 following an allegation of staff-to-resident abuse, where Resident #19 sustained nine separate wounds as a result of the incident. The facility failed to accurately identify and thoroughly investigate the allegation of staff-to resident abuse and RN #500 was permitted to return to work on 05/27/24, unsupervised, with Resident #19. The Immediate Jeopardy was removed on 06/06/24 when the facility implemented the following corrective actions: On 05/19/24 at 10:21 P.M., the Administrator opened as SRI for an injury of unknown origin. On 05/19/24 at 10:30 P.M., the Administrator interviewed RN #521, via phone, regarding Resident #19's injuries. Per RN #521, STNA #465 and STNA #501 reported Resident #19 had bruising and blood on her Geri sleeves. RN # 521 cleansed the resident's arms with normal saline (NS), applied Steri-Strips and xeroform dressing and wrapped the resident's arms in kerlix. RN #521 performed a skin assessment on Resident #19. On 05/19/24 at 10:57 P.M., RN #521 notified Certified Nurse Practitioner (CNP) #524 of Resident #19's new skin tears and bilateral bruising to her arms. New orders were obtained for bilateral x-rays of the resident ' s hands and arms. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/20/24 at 9:00 A.M., the DON interviewed RN #500, via phone, due to staff report of RN #500 feeling frustrated with Resident #19 on the night of the incident. RN #500 stated she took Resident #19 to her room, around dinner time, for approximately 10 minutes. RN #500 was suspended pending the outcome of the investigation. On 05/20/24, Assistant Administrator (AA) #523 interviewed 12 random staff; STNA #602, STNA #627, STNA #609, STNA #620, STNA #515, STNA #631, STNA #671, STNA #673, STNA #675, STNA #676, STNA #619, and Licensed Practical Nurse (LPN) #632 regarding witnessing abuse or reporting abuse, with no findings. On 05/20/24, beginning at 10:00 A.M. and completed on 05/24/24 at 8:30 P.M., Assistant Director of Nursing (ADON) #522 initiated Residents Rights and Abuse Inservice for all staff. This was completed in person and via phone. On 05/21/24 at 1:30 P.M., the Administrator and DON re-interviewed RN #500. No additional information was obtained. On 05/22/24, from 10:30 A.M. until 11:30 A.M., ADON #522 interviewed alert residents on the memory care unit regarding abuse reporting, witnessing abuse and ensured residents felt safe, with no negative findings. On 05/22/24 from 2:00 P.M. to 4:45 P.M., ADON #522 completed skin assessments on all residents on the memory care unit with no negative findings. On 05/24/24 at 7:21 P.M., an SRI for injury of unknown origin was closed with an unsubstantiated finding. No abuse concerns were identified. On 05/27/24 at 1:42 P.M., RN #500 was informed by the DON that Resident #19's family requested, due to the incident on 05/19/24, she no longer work with the resident. RN #500 was offered the option to work on another unit. RN #500 refused the reassignment and immediately terminated her employment at the facility. On 06/06/24 at 11:50 A.M., the Administrator, RDCS #510 and RDO #503 interviewed MD #750 regarding potential causes of Resident #19 's injuries on 05/19/24. MD #750 indicated ecchymosis (bruising) could be caused by natural handling of residents. On 06/06/24 at 12:00 P.M., the Administrator, RDCS #510 and RDO #503 completed a root cause analysis and determined a thorough investigation was not completed related to the incident involving RN #500 and Resident #19 on 05/19/24, and abuse likely occurred. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/06/24 at 12:15 P.M., an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator to review the Immediate Jeopardy findings and reviewed prevention of resident abuse and facility policies related to prevention, identification and investigation of allegations of resident abuse. The QAPI meeting was attended by the Administrator, RDO #503, RDCS #510, Transportation Director (TD) #525, Activities Director Assisted Living (ADAL) #526, Activities Director (AD) #900, Housekeeping and Laundry Director (HLD) #527, Medical Records Clerk (MRC) #528, Chaplin #529, Central Supply (CS) #530, Marketing Director #531, Scheduler #515, Human Resources Director (HRD) #520, Minimum Data Set Coordinator (MDSC) #532, Business Office Manager (BOM) #533, Admissions/Social Services Designee (SSD) #535, Assistant Administrator (AA) #523, and Director of Maintenance (DOM) #540. On 06/06/24 at 12:30 P.M., RDO #503 and RDCS #510 re-educated all department heads, including the Administrator and DON, on the facility's abuse policy and prevention, reporting and investigation of allegations of abuse. Additionally, education was provided related to SRI reporting categories. On 06/06/24 at 2:35 P.M., the Administrator filed a report with the Ohio Board of Nursing related to suspected resident abuse on 05/19/24 involving RN #500. On 06/06/24 at 2:45 P.M., the Administrator filed a police report with the local police department related to suspected staff-to-resident abuse on 05/19/24. On 06/06/24 from 8:00 P.M. through 9:30 P.M., department heads re-educated all staff on the facility's Abuse Policy, Abuse Prevention Policy and Abuse Investigation Policy. Staff who could not be reached for their education were left a voicemail message indicating they could not return to work until they received the education. Interviews on 06/06/24 from 8:12 P.M. through 8:15 P.M. of STNA #671, STNA #609 and RN #521 confirmed the facility provided education on the facility's abuse prevention and reporting policies and procedures. On 06/06/24 from 9:00 P.M. through 11:35 P.M., AA #523 completed interviews with all staff who worked on 05/17/24, 05/18/24 and 05/19/24, including STNA #465, STNA #600, STNA #501, STNA #601, STNA #602, STNA #603, STNA #604, STNA #605, STNA #606, STNA #607, STNA #608, STNA #609, STNA #470 and STNA #611, LPN #612, LPN #613, LPN #614, LPN #615 and LPN #616, RN # 617 and RN #521, AD # 900, Occupational Therapist (OT) #618, MRC #528, CS # 530, Marketing Director #531, TD #525, HRD #520, DOM #540 and SSD #535. Voicemail messages were left for those staff who could not be reached, including STNA #619, STNA #620, STNA #621, STNA #622, STNA #623, STNA #624, STNA #625, STNA #626, STNA #627, STNA #628, STNA #629, STNA #630 and STNA #631 and LPN #632, LPN #633 and LPN #634 to complete interviews. No new information or areas of concern were identified in the staff interviews. On 06/06/24 at 9:35 P.M., RDCS #510, RDO #503 and the Administrator interviewed Wound Care Certified Nurse Practitioner (WCCNP) #502 regarding Resident #19's injuries. WCCNP #502 indicated she could see how skin damage could be caused if staff were doing something with Resident #19 because the resident had thin, fragile skin and was elderly. On 06/06/24 from 10:00 P.M. through 11:30 P.M., the DON and ADON #522 completed skin audits on all residents. No negative findings were identified. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Weekly Skin Assessments from 04/01/24 through 05/18/24 for Resident #19 revealed two weekly skin assessments were documented, one on 04/19/24 at 6:45 A.M. completed by LPN #702 and one on 05/03/24 at 6:18 A.M. completed by LPN #703. Each assessment revealed Resident #19 had no bruises, skin tears, lesions, cuts or abrasions noted. Review of the nursing progress notes from 04/01/24 through 05/18/24 revealed no documentation of incidents of bruises, skin tears, lesions, cuts or abrasions for Resident #19. Review of the shower sheets for Resident #19, dated 03/02/24, 03/06/24, 03/08/24, 03/13/24, 03/23/24, 04/27/24, 05/01/24, 05/04/24, 05/08/24, 05/11/24 and 05/15/24 revealed no skin tears or bruising to the arms or face. Review of a nursing progress note, dated 05/19/24 at 10:11 P.M. completed by RN #521, revealed the STNA reported Resident #19 developed skin tears during the day. RN #521 went into the room and observed the resident had multiple skin tears to bilateral upper extremities and new bruising to both hands. Treatment was provided for the skin tears. RN #521 notified ADON #522 and the resident's daughter. A message was left for the on-call physician for MD #750, awaiting response. Review of a nursing progress note, dated 05/19/24 at 10:53 P.M. completed by RN #521, revealed Resident #19 had kerlix wrapped on her upper extremities before RN #521 cleansed the skin tears and rewrapped. RN #521 asked the STNA if Resident #19 had been wearing Geri sleeves during the day and the STNA confirmed Resident #19 had been wearing them. Review of the facility SRI revealed an injury of unknown origin was initiated by the Administrator for Resident #19, with a date of discovery of 05/19/24. Resident #19 complained of pain and the nurse medicated the resident. The nurse received report from staff that the resident was found with bruises and skin tears on bilateral arms. Resident #19 had a history of removing Geri sleeves and picking at skin. Staff became aware of the injuries on 05/19/24 at 9:45 P.M. The Administrator was notified at 10:00 P.M. by ADON #522, aids reported to the nurse and no other agencies were notified. Interventions included Geri sleeves were discontinued due to resident removing them, causing injury. Review of a wound care note, dated 05/22/24 and completed by WCCNP #502, revealed abnormal findings included traumatic lesion to the head and scattered bruising. Further review of the documentation revealed Resident #19 had six separate wounds, including skin tears and bruising, to her left upper arm, left forearm, left wrist, left inner forearm, right forearm, and right hand. Additionally, Resident #19 had a left cheek abrasion with bruising, right chin abrasion with bruising, and a left chest abrasion with bruising. Review of the daily schedule for 05/19/24 revealed from 2:30 P.M. through 6:30 P.M. a total of three staff members were scheduled for the unit Resident #19 resided on. The three staff members scheduled were RN #500, STNA #465 and STNA #501. Review of the facility investigation file revealed seven written staff statements. One from STNA #465, STNA #501 and STNA #607, two from RN #500, one from AD #900, and one from RN #521. STNA #607, AD #900 and RN #521 were not working during the time of the incident on 05/19/24. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a handwritten statement on lined notebook paper, dated 05/19/24 and untimed, revealed at mealtime, Resident #19 was yelling, screaming and was very disruptive. When STNA #501 removed the tray, she noticed blood on Resident #19's sleeves and reported this to the nurse. The nurse removed Resident #19 from the dining room and took her to her room. The statement included a cursive signature indicating STNA #465 signed the document. Review of a typed statement, dated 05/19/24 and untimed, revealed during dinner time, Resident #19 was making disruptive noises in the dining room. She was crying and screaming. While removing her dinner tray, blood stains were noted on her sleeves and the resident had bruising. STNA #501 reported this to the nurse, who removed Resident #19 and took her back to her room. The statement included a cursive signature indicating STNA #501 signed the document. Review of a typed witness statement, dated 05/20/24 and untimed, confirmed the DON completed a telephone interview with RN #500 related to the events on 05/19/24 with Resident #19. RN #500 indicated Resident #19 was aggressive toward her while attempting to administer medication. Review of a handwritten witness statement, completed by the Administrator and dated 05/21/24, revealed RN #500 was again interviewed over the phone, with the DON present, with no new information provided. Review of a typed statement, dated 05/19/24 and untimed, revealed the Administrator interviewed RN #521 via telephone. RN #521 stated he received in report Resident #19 had behaviors during the day and RN #500 had used derogatory language while speaking about the resident. The aides (STNA #465 and STNA #501) had reported Resident #19 had bruising and blood on her Geri sleeves. RN #521 provided treatment to the resident's arms and notified the Power of Attorney (POA), Certified Nurse Practitioner (CNP) and ADON #522 of new skin tears and bruising. Observation on 06/03/24 at 1:50 P.M. of Resident #19 revealed the resident was sitting in a wheelchair in her room. Resident #19 was calm and did not respond to questions asked by the surveyor. Resident #19 had bilateral Geri sleeves on, and a visible dressing was located on the right hand, partially covered by the Geri sleeve. The left side of Resident #19's face had three small red areas in a vertical line on the outer portion of her cheek. Resident #19 had a visitor who introduced herself as a sitter. Resident #19's daughter called the sitter on the phone and inquired who was in the room. Concurrent interview with Resident #19's daughter revealed she had a camera placed in the resident's room because Resident #19 was hurt by someone at the facility and received skin tears down her arms, a bruise to her right cheek and blood spots to the other side of her face. Resident #19's daughter revealed on 05/19/24 she received a phone call from RN #521, who stated two staff members reported there was an incident. Resident #19's daughter stated it was a nurse who caused the resident 's injuries and she subsequently quit after being offered assignment on another floor and refused. Interview on 06/03/24 at 1:57 P.M. with STNA #607 revealed she worked first shift (6:30 A.M. until 3:00 P.M.) on 05/19/24 with Resident #19, who had no injuries during her shift. STNA #607 stated she was interviewed by AA #523 regarding the incident. STNA #607 stated she heard RN #500 caused Resident #19's injuries but she had no direct knowledge of the incident between RN #500 and Resident #19 and asked AA #523 why she was not talking to the staff who were there during that time. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/03/24 at 4:49 P.M. and 06/04/24 at 4:42 P.M. with the DON confirmed the bruises on Resident #19's face were not mentioned in the SRI or in the nursing notes completed 05/19/24. The DON stated the bruises showed up a few days later and she did not know how Resident #19 got them because she did not investigate the cause. The DON revealed she concluded Resident #19 caused the bruises to her face and the skin tears to her arms herself from picking at the Geri sleeves. The DON confirmed there was no documentation in Resident #19's medical record from 04/01/24 through 05/19/24 of any picking at her Geri sleeves, causing self-inflicted skin tears or bruises. The DON stated Resident #19 had a low blood count, which could have caused the wounds. Interview on 06/04/24 at 2:53 P.M. with STNA #465 revealed on 05/19/24 she started her shift at 6:30 A.M. and worked until 11:00 P.M. STNA #465 stated when she started her shift, Resident #19 had no skin tears or bruising. STNA #465 confirmed she witnessed the incident on 05/19/24 at approximately 5:30 P.M. between RN #500 and Resident #19, in which RN #500 used derogatory language, removed the resident from the dining room, remained alone with the resident in her room and the resident subsequently had nine wounds. STNA #465 reported RN #500 stated the resident had three new skin tears because they got into it and referred to Resident #19 in a derogatory manner. STNA #465 stated RN #521 came in at 6:30 P.M. and both she and STNA #501 told him he needed to look at Resident #19 because her wounds were bad. RN #521 assessed Resident #19 and reported the incident. STNA #465 confirmed she wrote a witness statement on 05/19/24. Interview on 06/04/24 at 3:13 P.M. with STNA #501 revealed she started her shift at 2:30 P.M. on 05/19/24. Resident #19 was her assigned resident, and she had no skin tears or other injuries. STNA #501 verified she witnessed the incident between RN #500 and Resident #19 on 05/19/24, reporting around dinner time, RN #500 stated she had enough of Resident #19, removed her from the dining room, and was alone with the resident in her room. Resident #19 was heard screaming and after RN #500 exited the resident's room, the resident had blood on her Geri sleeves and upper arms and bruising on her hand. STNA #501 reported RN #500 stated Resident #19 was something else, she tried to get me, and we got into it. STNA #501 confirmed she reported the incident to RN #521 when he arrived for his shift at 6:30 P.M. and a handwritten witness statement was completed before she left that night. Review of the witness statement, handwritten on notebook paper and dated 05/19/24, on 06/04/24 at 4:35 P. M. with STNA #465, revealed the document signed with STNA #465's name was not the statement she had written on 05/19/24. STNA #465 further confirmed the handwriting and signature on the document was not hers, her statement was written on plain white paper (no lines) and the statement did not reflect her report of events on 05/19/24. STNA #465 stated her earlier interview with the surveyor was what she had written in her witness statement. STNA #465 had no knowledge of who wrote the statement that was included in the facility investigation and verified the facility administration never interviewed her regarding the incident on 05/19/24. Interview on 06/04/24 at 4:23 P.M. with the Administrator confirmed a police report was never filed regarding the incident on 05/19/24 between RN #500 and Resident #19, nor was RN #500 reported to the Ohio Board of Nursing for suspected abuse. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/05/24 at 10:52 A.M. with WCCNP #502 revealed she had never visited Resident #19 prior to 05/22/24 and noted the resident had multiple skin tears during her assessment on 05/22/24. WCCNP #502 stated bruising could occur easier with contact if the person had a low blood count and low platelets. However, WCCNP #502 confirmed Resident #19's skin tears and abrasions were not consistent with low hemoglobin, and they were not consistent with self-picking. WCCNP #502 stated Resident #19 had no evidence of fingernail scratches, which would likely be seen if someone was self-picking their skin. Additionally, WCCNP #502 stated Steri-Strips were needed to reapproximate the skin flaps, also not consistent with skin picking. WCCNP #502 stated she did not believe Resident #19's wounds were the result of skin picking or low hemoglobin levels. WCCNP #502 confirmed she was not interviewed regarding her assessment findings and opinion regarding Resident #19's wounds. Interview on 06/05/24 at 12:27 P.M. with the DON verified RN #500 was permitted to return to work on Resident #19's unit on 05/27/24. RN #500 quit at approximately 1:42 P.M. that day, after Resident #19's family requested she not work with the resident following the incident on 05/19/24. The DON confirmed RN #500 was offered reassignment to another floor, but she refused, and terminated her employment that day. Review of the typed witness statement dated 05/19/24 and located in the facility's investigation file, on 06/05/24 at 3:23 P.M. with STNA #501 revealed the statement was not the handwritten statement she completed on 05/19/24, following the incident with RN #500 and Resident #19. STNA #501 stated she completed a handwritten statement, not typed. STNA #501 stated I wrote my own statement. I did not sign this. This is not mine. I have never seen this before. What I told you was accurate. That is my name, but I did not say that or sign that. Where is mine? STNA #501 verified she was not interviewed by the facility administration regarding the incident on 05/19/24. Interview on 06/05/24 at 3:40 P.M. with MD #750 confirmed he was the primary care physician for Resident #19. MD #750 revealed Resident #19's platelets were not low enough to cause spontaneous bleeding. MD #750 stated he was unaware of the extent of the incident involving RN #500 and Resident #19 and verified he had not been interviewed by the facility regarding the resident's injuries. Interview on 06/05/24 at 4:30 P.M. with the DON revealed STNA #465 and STNA #501's witness statements included in the facility's investigation file were placed under the Administrator's door. The DON stated she assumed both STNA #465 and STNA #501 wrote the statements themselves. The DON confirmed STNA #465 and STNA #501 were the only two staff members present during the incident and confirmed neither were interviewed. The DON stated she did not know where STNA #465 and STNA #501's written statements from 05/19/24 were and did not know where the two statements included in the investigation file came from. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/05/24 at 4:34 P.M. with Administrator revealed she did not know if the witness statements included in the facility investigation from STNA #465 and STNA #501 were placed under the DON's door or hers after they were written. The Administrator stated she did not know who wrote or signed the witness statements and confirmed there were no other witness statements she had from STNA #465 or STNA #501. The Administrator verified she did not interview either STNA #465 or STNA #501, who were the only staff witnesses, regarding the incident. The Administrator stated she interviewed RN #500, who she thought was the important one to interview. The DON entered during the interview with the Administrator. Both the DON and the Administrator confirmed STNA #465 and STNA #501 were the only two witnesses and neither were ever interviewed regarding the incident on 05/19/24 between RN #500 and Resident #19. Additionally, the DON and Administrator confirmed neither WCCNP #502 nor MD #750 were interviewed regarding Resident #19's injuries. Both stated they suspected Resident #19's injuries were due to Resident #19 having a low platelet count and picking her own skin. Interview on 06/06/24 at 8:15 P.M. with RN #521 revealed on 05/19/24 he began his shift at 6:30 P.M. RN #500 gave him the nursing shift to shift report, using an explicative to describe Resident #19, and stated the resident had behaviors and got skin tears. RN #521 stated he notified the physician, family, and ADON #522 of the resident's wounds. RN #521 confirmed both STNA #465 and STNA #501 provided handwritten statements that night on plain white paper, and he placed them in the DON's mailbox. Review of the policy titled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property revised 11/01/19 revealed the facility will not tolerate Abuse, Neglect, Exploitation or the Misappropriation of Resident Property. Facility staff should immediately report all such allegations to the Administrator/designee and to the Ohio Department of Health (ODH). In cases where a crime is suspected, staff should also report the same to local law enforcement. The definition of abuse included the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse. In the case of staff to resident abuse, the facility will follow the facilities procedure for discipline or dismissing an employee depending on the circumstances and results of the investigation. The investigation protocol included to interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident, came in close contact with the resident the day of the incident and employees who worked closely with the accused employee the day of the incident. This deficiency represents non-compliance investigated under Complaint Number OH00153215.		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on closed medical record review, hospital record review, staff interviews, and review of facility policy, the facility failed to ensure physician ordered treatments were provided to promote healing of a surgical wound. Actual Harm occurred when Resident #90's surgical wound was not assessed until five days after admission and had 60% slough over then wound, physician ordered treatments were not administered as ordered leading to infection of the surgical wound, requiring a seven-day hospitalization, treatment with intravenous antibiotics, and the placement of a wound vacuum for healing. Upon readmission to the facility, the facility failed to initiate the physician order for a wound vacuum for the surgical wound site for three days and then failed to apply and change as ordered. This affected one (#90) of four residents reviewed for wounds. The facility census was 86. Findings include: Review of Resident #90's closed medical record revealed an admitted [DATE], with re-admitted [DATE] and a discharge date of [DATE]. Diagnosis included unspecified open wound of the abdominal wall with right upper quadrant without penetration into peritoneal cavity. Review of the Admission assessment dated [DATE] revealed Resident #90 had an abdominal surgical incision. There was no description or measurement of the wound. Review of the care plan for Resident #90 dated 04/08/24 revealed Resident #90 had an actual impairment to skin integrity of the mid abdomen related to a surgical wound. Interventions included to follow facility protocols for treatment of injury. Review of the Weekly Wound observation tool assessment dated [DATE] at 8:19 P.M., completed by ADON #522 revealed Wound Care Certified Nurse Practitioner (WCCNP) #502 was in for initial evaluation, wound located on the abdomen, 40% granulation, 60% slough, 12.0 centimeters (cm) by 3.7 cm by 2.1 cm depth, well approximated, sutures intact to center of the wound bed, continue surgical orders and apply Santyl to wound bed. Further review revealed evidence Resident #90's wound was assessed on 04/17/24. Review of the re-admission Medicare five-day [NAME] Data Set assessment dated [DATE] revealed Resident #90 was cognitively intact. Resident #90 had no impairment of upper extremities, impairment both sides lower, required supervision or touch assist with toileting, bathing, transfers, set up or clean up assist with dressing, bed mobility, always continent of bowel and bladder, had two venous/arterial wounds and had a surgical wound. Review of the monthly physician orders for April and May 2024 revealed Resident #90 had the following orders: cleanse abdominal area with normal saline (NS), apply Santyl, then wet to dry saline-soaked gauze, cover with ABD (abdominal dressing) every shift (two times daily, day and night shifts). The order was placed on hold from 04/11/24 to 04/12/23 and discontinued on 04/12/24; initiated on 04/19/24 and discontinued on 04/23/24, Santyl external ointment 250 units per gram, apply to abdominal wound topically every shift for wound; 05/04/24, wound documentation every shift; and 05/07/24, ensure follow up set up with wound care center. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Treatment Administration Record (TAR) for April 2024 revealed no evidence wound care was completed for Resident #90 on 04/06/24 night shift, 04/07/24 on day shift or night shift, 04/19/24 night shift, and 04/20/24 day shift or night shift. Review of a progress note dated 04/23/24 at 11:09 A.M. and completed by LPN #903 revealed Resident #90 had purulent wound drainage from the abdominal wound. Review of a progress note dated 04/23/24 12:47 P.M. and completed by LPN #903 revealed Resident #90 was sent to the emergency room (ER) related to abnormal vital signs, altered mental state (AMS), and ROM (range of motion). Review of the hospital History and Physical (H&P) completed by Hospital Physician #901 revealed Resident #90 had an ulcer wound on the right side of her abdomen. Upon removing the bandage, the wound had some purulent discharge with some surrounding erythema. Intravenous antibiotics were started. Further review of the After-Visit Summary for Resident #90 revealed the resident was hospitalized on [DATE] and discharged on [DATE] for an infected wound. Discharge wound care instructions included: wound site abdomen, change dressing as needed, cleanse with NS, apply bacitracin and zinc oxide and continuous wound vacuum (vac) at 125 mm/hg (millimeters of mercury). Review of a progress note dated 04/29/24 at 5:50 P.M. completed by Assistant Director of Nursing (ADON) #522 revealed Resident #90 arrived from the hospital post hospitalization for hypotension and sepsis. Further review of the TAR from 04/30/24 through 05/13/24 revealed no wound care treatments were documented as provided for Resident #90. Additional review of the physician orders, dated 05/02/24 and discontinued 05/13/24, revealed abdominal wound vac at 125 mm/hg and apply bacitracin and zinc oxide. Review of a progress note dated 05/03/24 at 12:29 A.M. completed by LPN #904 revealed Resident #90 removed her wound vac because it kept beeping and she stated it had too much tape on it. A wet to dry dressing was applied. Further review of the medical record revealed no evidence the physician was notified on 05/03/24 of the new dressing applied and there was no order for wet to dry dressing. Review of a progress note dated 05/08/24 at 4:07 A.M. completed by LPN #905 revealed the nurse was called to Resident #90's room by the STNA. The resident removed her wound vac and stated it fell off. The abdominal area was cleansed and a wet to dry dressing was placed. Further review of the medical record revealed no evidence the physician was notified on 05/08/24 of the new dressing applied and there was no order for wet to dry dressing. Review of the Wound Weekly Observation Tool for Resident #90 dated 05/08/24 at 11:11 A.M., completed by ADON #522, revealed WCCNP #502 was onsite for follow-up. The documentation stated the abdomen wound was improving with granulation, 40% slough. There was also 1.4 cm additional measurement. The peri wound was excoriated. Wound vac at 125 mmHg continuous. Further review of the medical record revealed no evidence of a corresponding WCCNP #502 progress note. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 05/09/24 at 6:38 A.M. completed by Registered Nurse (RN) #617 revealed Resident #90 had the wound vac dressing completely off with drainage all over the abdomen, drainage from peg tube under her breast, red and excoriated skin all over the abdomen, and under and over breasts. Resident #90 was noncompliant, constantly picking at dressings and wounds. Review of a progress note dated 05/12/24 at 11:09 A.M. by the Director of Nursing (DON) revealed Resident #90 was sent to the ER due to resident having an emesis after a fall. Review of a progress note dated 05/13/24 at 12:04 P.M. completed by the DON revealed she phoned the hospital and spoke to the nurse in the stepdown intensive care unit (SICU). Resident #90's admitting diagnosis was encephalopathy (brain dysfunction). Interview on 06/04/24 at 10:21 A.M. with ADON #522 confirmed Resident #90 returned from the hospital on 04/29/24. ADON #522 verified Resident #90 had orders for a wound vac upon readmission and physician orders for the wound vac were not placed until 05/02/24 (three days after readmission). ADON #522 confirmed the orders did not specify how frequently to change the wound dressing, which she stated should have been three times a week and as needed per protocol for a wound vac. ADON #522 stated the floor nurses changed Resident #90's wound vac dressings while she resided at the facility. Resident #90's medical records were reviewed with ADON #522, which included physician orders, Medication Administration Record (MAR), and TAR. ADON #522 confirmed the wound vac orders were not located on the MAR or TAR for April or May 2024 for the nurses to view and complete the orders. ADON #522 stated the nurse who placed the order in the electronic medical record (EMR) did not place the order on the TAR, which did not allow the nurses to see the order when they viewed the treatment record. ADON #522 verified the nurses would not have seen the order for the scheduled wound treatments due to the orders being incorrectly placed in the EMR, resulting in nurses not completing the order per physician order/protocol for the routine wound vac dressing changes. ADON #522 verified there was no documentation of wound care treatments being completed on 04/06/24 night shift, 04/07/24 on day shift or night shift, 04/19/24 night shift, 04/20/24 day shift or night shift or from 04/30/24 through 05/12/24. Interview on 06/05/24 at 11:08 A.M. with WCCNP #502 revealed the wound vac not being changed as ordered could have caused the excoriation on Resident #90's abdomen when she assessed her on 05/08/24. Additionally, WCCNP #502 verified not completing treatments could have caused worsening of the wound. WCCNP #502 stated wound vac dressings were to be changed three times a week and as needed. WCCNP #502 confirmed on 05/08/24, Resident #90's wound was improving but stated that was only part of the wound. While the actual outside of the wound was getting smaller, showing improvement, the inside of the wound had new undermining, which was not improvement, and the wound was getting worse. WCCNP #502 stated that was the reason she wanted Resident #90 to go to the wound clinic. Review of the facility policy titled Wound Care, revised October 2010, revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing, which included verifying physician orders. This deficiency represents non-compliance investigated under Complaint Number OH00154034.		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, review of medical records, interviews with staff, review of hospital records, review of the Certificate of Death, review of the National Pressure Injury Advisory Panel (NPIAP) and review of the facility policy, the facility failed to provide necessary care and services to prevent and subsequently promote healing and/or worsening of a facility acquired pressure ulcer. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, and/or death, when the facility failed to implement interventions to prevent the development of a facility acquired pressure ulcer, such as turning and repositioning and incontinence care for Resident #91, who was at risk for pressure ulcer development. Furthermore, the facility failed to timely and accurately complete skin assessments to identify the resident 's pressure ulcer, failed to complete wound assessments and failed to provide the necessary care and treatments to promote healing and/or worsening of the wound. Consequently, on [DATE], Resident #91 was transferred to the hospital and admitted due to a fall and weakness secondary to Escherichia coli (E. Coli) bacteremia from an infected decubitus ulcer (pressure ulcer). Resident #91 subsequently died on [DATE]. The primary cause of death was E. coli sepsis (A life-threatening complication of an infection) due to an infected decubitus ulcer. Additionally, Actual Harm occurred to Resident #34, who was at risk for pressure ulcer development and dependent on staff for turning and repositioning and incontinence care, when Resident #34 was not provided weekly assessments of a stage three pressure ulcer, physician ordered pressure ulcer treatments were not completed as ordered, and the resident was subsequently admitted to the hospital on [DATE] with septic shock in setting of coccygeal wound. Lastly, the facility failed to provide care and services for the prevention, identification, and treatment of a pressure ulcer at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) for one (#40) additional resident reviewed for pressure ulcers. This affected three (#91, #34, #40) of four residents reviewed for pressure ulcers. The facility identified a total of 13 residents with pressure ulcers. The facility census was 86. On [DATE] at 1:49 P.M., the Administrator and Regional Director of Clinical Services (RDCS) #510 were notified Immediate Jeopardy began on [DATE] when Resident #91 when was identified to have a pressure wound to the right and left buttocks. Assistant Director of Nursing (ADON) #522 verified wound treatments to the right and left buttocks were not completed as ordered and could not verify Resident #91 received any care planned interventions for the prevention of pressure ulcers. On [DATE], the wound on the left and right buttock merged into one large wound to the sacrum, measuring 7.0 centimeters (cm) by 6.0 cm by 0.0 depth. The wound was noted with inflammation and induration (hardening of the skin and subcutaneous tissue, which may be secondary to infection). The wound had 10% granulation, 90% slough, moderate amount of serosanguinous drainage, and surgical debridement was provided. Resident #91 was not treated for any infection while at the facility. On [DATE], Resident #91 was sent to the hospital following a fall. The hospital notes indicated Resident #91 was admitted after a fall and weakness secondary to E. coli bacteremia from an infected decubitus ulcer. Resident #91 was subsequently discharged from the hospital to hospice care on [DATE] and died on [DATE]. Review of the death certificate revealed the immediate cause of death was E. coli sepsis due to an infected decubitus ulcer. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] between 2:09 P.M. and 5:49 P.M., Regional Minimum Data Set Coordinator (RMDSC) #914 and Minimum Data Set Coordinator (MDSC) #915 completed an assessment of all resident care plans to ensure they were updated with appropriate interventions to prevent and treat pressure ulcers. On [DATE] between 2:20 P.M. and 8:10 P.M., Licensed Practical Nurse (LPN) #916, LPN #917 and ADON #522 completed a skin assessment on all residents. There were no new wounds noted on the whole house skin assessments. On [DATE] at 2:45 P.M., a Root Cause Analysis was completed by RDCS #510, Regional Director of Operations (RDO) #503 and the Administrator. It was determined the Root Cause was the Director of Nursing (DON) and ADON #522 did not ensure preventative interventions and necessary care and treatments were in place to prevent, promote healing and/or worsening of Resident #91's wound. On [DATE] at 2:58 P.M., RDCS #510 re-educated ADON #522 on the facility's Wound Care policy, Prevention of Pressure Ulcers/Injuries, and New Admission/Re-Admission Skin and Wound Care Best Practices Policy. RDCS #510 will provide the education to the DON prior to returning to work on [DATE]. On [DATE] from 3:15 P.M. through 5:30 P.M., RDCS #510 provided in-service education for all licensed nurses, in person and via telephone, on the facility's Wound Care Policy, Prevention of Pressure Ulcers/Injuries, and New Admission/Re-Admission Skin and Wound Care Best Practices Policy. The following licensed nurses received the education: LPN #918, LPN #919, LPN #920, LPN #921, LPN #615, LPN #632, LPN #634, LPN #922, LPN #923, LPN #924, LPN #925, LPN #926, and Registered Nurse (RN) #521. Any licensed nurse who could not be reached will receive the education from ADON #522 or RDCS #510 prior to their next scheduled shift. On [DATE] at 4:12 P.M., an AD Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator, with Medical Director (MD) #750, to review the Immediate Jeopardy findings, discuss ensuring necessary care and treatments are in place to prevent and promote healing and/or worsening of wounds, and review facility policies related to prevention, identification, and investigation. Additional QAPI meeting attendees included RDO #503, RDCS #510, MDSC #915 (via phone), RMDSC #914 (via phone), and Assistant Administrator (AA) #523. On [DATE] from 5:40 P.M. through 8:30 P.M., RDCS #510 provided wound care education, including policies and procedures, in person and via telephone, for State tested Nursing Assistants (STNA) #932, STNA #933, STNA #934, STNA #608, STNA #627, STNA #609, STNA #501, STNA #935, STNA #936, STNA #602, STNA #625, STNA #911, STNA #624, STNA #628, STNA #607, STNA #622, STNA #937, STNA #938, STNA #620, STNA #939, STNA #604, STNA #629, STNA #940, STNA #673 and STNA #941. Any STNA who could not be reached will receive the education from the DON or designee prior to their next scheduled shift. On [DATE] from 6:00 P.M. through 8:00 P.M., RDCS #510 completed a Braden Scale (assessment used for predicting pressure ulcer risk) audit for all residents. Beginning on [DATE], the DON or designee will audit all new admissions, Monday through Friday, for four weeks to ensure skin prevention/treatment orders are in place, Braden Scale orders are in place and skin prevention and wound care interventions appropriately care planned. The audits will be completed within 48 hours of admission. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on [DATE], the DON or designee will audit all weekly skin assessments, Monday through Friday, for four weeks to ensure all assessments are completed accurately and any identified areas of concern are timely assessed and treated. Beginning on [DATE], the DON or designee will visually validate all wound treatments are completed as ordered and audit the Treatment Administration Record (TAR) Monday through Friday for four weeks to ensure all treatments have been signed off on the TAR. Beginning on [DATE], the DON or designee will audit all residents with wounds weekly for four weeks to ensure weekly wound assessments are completed, monitor for wound progress and ensure treatment orders and appropriate care plan interventions are in place for each wound. Beginning on [DATE], the DON or designee will audit seven incontinent residents daily, Monday through Friday for four weeks to ensure incontinent residents were checked and changed and incontinence care provided. Beginning on [DATE], the QAPI committee will meet weekly for four weeks, then monthly thereafter, to review all audit findings to ensure continued compliance. Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1) Review of Resident #91's closed medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included fracture of unspecified part of neck of right femur, muscle weakness, and the need for assistance with personal care. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #91 was moderately cognitively impaired. Resident #91 had no impairment to the upper extremities and had impairment to one side of the lower extremities. Resident #91 was dependent for activities of daily living (ADLs), including toileting, bathing, dressing, bed mobility and transfers. Resident #91 was always incontinent of bowel and bladder, was at risk for pressure ulcers and had no pressure ulcers. Resident #91 had a surgical wound and skin tears and received surgical wound care. Review of the Admit Screener, dated [DATE] at 2:26 P.M. and completed by ADON #522, revealed Resident #91 was admitted from the hospital with an admitting diagnosis of fractured right hip, status post repair of the right hip fracture. Resident #91 ' s skin color was normal, temperature was warm, turgor was normal, and the resident had a right trochanter hip surgical incision and left forearm skin tear. The assessment indicated diffuse bruising to her bilateral arms, thighs and knees as well as the area surrounding the surgical site. Resident #91 was alert and oriented to person. Review of the Braden Scale, dated [DATE] at 2:24 P.M. and completed by ADON #522, revealed Resident #91 was at risk for pressure sores. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the care plan, dated [DATE], revealed Resident #91 had potential/actual impairment to skin integrity. Interventions included air mattress in place, encourage to turn and reposition with rounds every two hours and as needed and tolerated. Further review of the care plan revealed a focus area created on [DATE] to include Resident #91 had an ADL self-care performance deficit. Interventions included staff to turn and reposition in bed and as necessary, required skin inspection, observe for redness, open areas, scratches, cuts, bruises, and report changes to nurse. Additionally, Resident #91 had bladder incontinence. Interventions included to clean the peri area with each incontinent episode. Lastly, review of a care plan focus area created on [DATE] (six days after Resident #91's discharge), revealed the resident had an unstageable pressure ulcer to her sacrum related to immobility. Interventions included administer treatments as ordered and monitor for effectiveness, avoid positioning the resident on sacrum, assist to turn and reposition at least every two hours and more often as needed or requested. Review of the physician orders for Resident #91 revealed the following orders: initiated [DATE], pressure reducing mattress to bed; initiated [DATE] and discontinued [DATE], cleanse right buttocks open area with normal saline (NS) and pat dry, apply foam dressing daily and as needed (PRN); initiated [DATE] and discontinued [DATE], cleanse left buttock with NS and pat dry, apply collagen and foam dressing daily and PRN; initiated [DATE], air mattress to bed; initiated [DATE], cleanse sacral wound with NS and apply mesalt daily and PRN every night shift for wound management; initiated [DATE], cleanse sacral wound with NS and apply mesalt daily and PRN every night shift and as needed if soiled for wound management; and initiated [DATE], cleanse sacral wound with NS, apply mesalt and apply foam dressing daily and PRN. Further review of physician orders revealed Resident #91 had no orders for antibiotics during her stay at the facility. Additional review of Resident #91's medical record revealed no evidence of wound assessments, including measurements or description of the pressure ulcers identified in physician orders beginning on [DATE]. Review of the TAR for [DATE] revealed the wound care to Resident #91's left, and right buttocks was not documented as completed on [DATE] or [DATE]. Further review of the TAR for [DATE] revealed the wound care to Resident #91 ' s sacral wound was not documented as completed on [DATE] or [DATE]. Review of the Wound Weekly Observation Tool for Resident #91, dated [DATE] at 11:58 P.M. and completed by ADON #522, revealed Wound Care Certified Nurse Practitioner (WCCNP) #502 was in for initial evaluation of Resident #91 ' s wound. Family was notified on [DATE], resident is on turning and repositioning routine, wound to sacrum acquired, pressure 10% granulation 90% slough, moderate amount serosanguinous drainage, surgical debridement provided, wound measured 7.0 centimeter (cm) by 6.0 cm by 0.0 cm depth with inflammation and induration present. Review of WCCNP #502's visit note, dated [DATE], revealed Resident #91 was seen for an initial visit for wound care services. Resident #91 had a wound located on the sacrum. The wound was moderate in severity. The wound was an unstageable pressure ulcer with obscured full thickness skin and tissue loss. The wound measurement was seven cm in length by six cm in width with no measurable depth. The note further indicated the wound had a moderate amount of serosanguinous drainage, noted to have no odor. The peri wound did not exhibit signs and symptoms of infection. Lastly, the wound had 90% slough and 10% granulation tissue. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of WCCNP #502's visit note, dated [DATE], revealed Resident #91 was being seen for a follow up visit for wound care services. Documentation included the unstageable pressure ulcer was full thickness with 20% granulation, 30% slough, 40% necrotic and 10% epithelial. There was moderate serosanguinous exudate and signs and symptoms of infection included odor. The wound was debrided to reduce bacterial load, will consider switching to Dakins next week if no improvement. Wound size was documented at 8.4 cm by 9.9 cm with an undetermined depth. Recommendations included a pressure reduction mattress per facility protocol and reposition per facility protocol. Interview on [DATE] at 1:58 P.M. and [DATE] at 11:30 A.M. with ADON #522 revealed Resident #91 had no pressure wounds on admission and developed a facility acquired stage three pressure ulcer. ADON #522 stated the wound started as two wounds, one on the right buttock and one on the left. ADON #522 confirmed there was no documentation to include the description of the wounds and measurements in the medical record for Resident #91's wounds to the right and left buttocks. ADON #522 revealed the two pressure wounds merged together as one sacral wound. ADON #522 stated she did not know if the staff were turning and repositioning Resident #91. ADON #522 further stated It was found at a stage three, it was bad when I looked at it, that shouldn't happen. ADON #522 revealed when she completed rounds, there were times she found wound dressings dated several days prior, indicating treatments had not been completed, but the nurses were still signing the TAR as completed. ADON #522 reviewed Resident #91 's TAR and confirmed there was no evidence the resident 's treatments were completed on [DATE], [DATE], [DATE] or [DATE]. Additionally, ADON #522 verified there was no evidence in the medical record revealing when the resident transferred to the hospital or why. ADON #522 confirmed the resident was transferred to the emergency room (ER) on [DATE]. Interview on [DATE] at 10:57 A.M. with STNA #906 confirmed she worked with Resident #91 and remembered the resident. STNA #906 stated Resident #91's wound care dressings were not getting done consistently. STNA #906 stated Resident #91 would have a bowel movement and the stool would be impacted in the wound. STNA #906 revealed she would clean the stool out of the wound with wipes then saline and stated, Sometimes the nurses would not put the dressing back on, sometimes there was no dressing when I came on my shift and all day. A follow-up interview on [DATE] at 3:10 P.M. with ADON #522 revealed she initiated Resident #91's wound care on [DATE] and obtained the orders for the treatments to the right and left buttocks. ADON #522 confirmed she looked at the wounds, confirmed they were pressure wounds but did not measure the wounds, describe the wounds, or place any identifiable information describing the wounds in Resident #91's medical record. Review of the hospital admission note, dated [DATE], and an undated hospital physical examination at discharge, completed by Physician #907, revealed Resident #91 was admitted to the hospital after a fall and weakness secondary to E. coli bacteremia from an infected decubitus ulcer. Review of the Certificate of Death, dated [DATE] and signed by Registrar #908, revealed Resident #91's date of death was [DATE]. The immediate cause of death was E. coli sepsis due to an infected decubitus ulcer. 2) Review of Resident #34's medical record revealed an admitted [DATE] and re-admitted [DATE]. Diagnoses included type two diabetes mellitus with diabetic neuropathy and other skin ulcers, stage three pressure ulcer of sacral region, muscle weakness, and need for assistance with personal care. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 was cognitively intact. Resident #34 was dependent for toileting, dressing, personal hygiene, and required substantial/maximal assistance for bed mobility. Resident #34 was always incontinent of bowel and bladder. Resident #34 was at risk for pressure ulcers and had one stage three pressure ulcer that was present upon admission and received pressure ulcer care. Review of the care plan, dated [DATE], revealed Resident #34 was always incontinent of bowel. Interventions included: checking the resident every two hours and assisting with toileting as needed. Additionally, Resident #34 had one pressure ulcer wound on the sacrum (stage three). Interventions included: to provide treatments as ordered and to educate the resident, family, and caregivers as to causes of skin breakdown including transfer/positioning requirements and frequent repositioning. Record review of Resident #34's monthly physician orders for [DATE] and [DATE] revealed orders for: Cleanse sacral wound with NS, pat dry and apply collagen to the wound bed. Cover with bordered foam dressing daily and PRN. The order was discontinued [DATE]; initiated on [DATE] and discontinued on [DATE], cleanse sacral wound with NS, pat dry, apply collagen to the wound bed followed by calcium alginate and cover with bordered foam dressing daily and PRN every night shift for wound management; initiated [DATE], cleanse sacral wound with NS, pat dry, apply Medi honey to the wound bed followed by calcium alginate and foam every night shift; and initiated [DATE], turn and reposition every two hours as tolerated while in bed. Review of the Wound Weekly Observation Tool dated [DATE] at 10:33 P.M. and completed by ADON #522 revealed WCCNP #502 onsite to follow up. Resident #34's sacral wound noted to be 80% granulation, 10% slough 10% epithelial and measured 1.4 cm in length by 0.6 cm in width by 1.0 cm in depth. The wound was unchanged. Further review of the medical record revealed there were no further Wound Weekly Observation Tools completed for Resident #34 in the medical record until [DATE]. Review of the TAR from [DATE] through [DATE] revealed both night shift wound treatment orders (cleanse sacral wound with NS, pat dry, apply collagen to the wound bed followed by calcium alginate and cover with bordered foam dressing daily and as needed every night shift initiated [DATE] and cleanse sacral wound with NS, pat dry, apply Medi honey to the wound bed followed by calcium alginate and foam every night shift initiated [DATE]) were both signed as completed on [DATE] and [DATE]. Review of the progress note dated [DATE] at 7:18 P.M. and completed by LPN #616 revealed Resident #34 returned from dialysis early due to leg/buttocks pain. Resident #34 was feeling blah today, complained of not being able to grab things with her left hand. Resident #34 was encouraged not to keep holding her cell phone in her left hand for long periods of time. Vital signs stable. Plan of care continues. Review of the change in condition evaluation, dated [DATE] at 7:53 A.M. and completed by LPN #616, revealed Resident #34's blood pressure was ,d+[DATE], pulse was 64, respirations 20 and temperature was 97.5 degrees Fahrenheit (F). Review of a progress note dated [DATE] at 1:12 P.M. and completed by LPN #616 revealed at 7:30 A.M., Resident #34 complained of dropping things from her left hand. The on-call Nurse Practitioner (NP) was called, and new order received to send resident to the emergency department (ED) for an evaluation. Resident sent to ED this morning. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a progress note, dated [DATE] at 1:12 P.M. and completed by LPN #616, revealed the nurse called the ED for a status update on Resident #34. Resident #34 was being admitted to the Intensive Care Unit (ICU) for septic shock. Review of the Nursing Re-admit Assessment completed [DATE] at 11:45 P.M. and completed by LPN #894, revealed Resident #34 was readmitted from the hospital with an admitting diagnosis of septic shock. Review of the hospital discharge summary, dated [DATE] and completed by Physician #891, revealed Resident #34 was admitted to the ICU and transferred to the medical floor following stabilization. Resident #34 was treated for septic shock in setting of both coccygeal wound and possible proctitis (inflammation of the rectum). Resident #34 was treated with linezolid (antibacterial) and Zosyn (antibiotic) during hospitalization . Review of the re-admission physician orders for Resident #34's wound care to the coccyx included: sacrum: Cleanse with NS, pat dry, apply Dakins ' s wet to dry, cover with ABD (abdominal dressing) and secure with paper tape every day shift. The order was initiated [DATE] and discontinued [DATE]. Further review of physician orders revealed on [DATE], a new order was initiated to cleanse the sacral wound with NS, apply Medi honey, calcium alginate and cover with foam dressing daily and PRN every night shift for wound management. The order was discontinued on [DATE]. Review of the TAR for Resident #34 from [DATE] through [DATE] revealed both treatments were signed off daily from [DATE] through [DATE]. Wound care to the coccyx was not documented as being completed on [DATE] or [DATE]. On [DATE], the cleanse sacral wound with NS, apply Medi honey, calcium alginate, cover with foam dressing daily treatment was initialed. Interview on [DATE] at 10:45 A.M. with Resident #34 revealed she had a sacral pressure ulcer. Resident #34 revealed the staff were supposed to change her wound dressing every day, but they did not. Resident #34 stated she was supposed to be turned every two hours but was only turned once a day. Resident #34 revealed the last time she was changed for incontinence was at 4:00 A.M. and needed changed now but the STNAs did not have time. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on [DATE] at 11:13 A.M. of incontinence care provided by STNA #460 for Resident #34 revealed Resident #34 had a large bowel movement (stool). The stool was partially dried on Resident #34's skin. Resident #34 had a boarder dressing to the sacral area. The dressing was partially lifted at the bottom and there was visible stool under the dressing. STNA #460 revealed this was the first time on this day she was able to assist Resident #34 with incontinence care (nearly five hours after her shift began). STNA #460 stated there were not enough staff and too many residents who required total care. STNA #460 revealed residents were usually provided incontinence care at least once per shift, some were changed twice per shift and expressed she could not reposition Resident #34 every two hours as there was just not enough staff, and she could not do it all. STNA #460 stated, Oh, that must be poop (referring to the contents under the dressing located on Resident #34's sacrum). While cleaning the stool from Resident #34's buttocks, STNA #460 removed the dressing from Resident #34's sacrum. STNA #460 then took the same washcloth and cleaned the stool from the wound while rubbing the wound with the soiled washcloth. STNA #460 stated she would apply another dressing to the wound bed if there was one in the room. STNA #460 reported the STNAs reapplied wound dressings when residents were incontinent and had stool on them. STNA #460 then began looking around the room for a wound dressing to apply. The wound to the sacrum was exposed, the wound bed had visible slough, the surrounding tissue was red with visual remnants of stool that remained on the wound bed. STNA #460 revealed there was not another dressing and left the room revealing she would get the nurse to apply the dressing. A nurse did apply a new dressing after the surveyor left. Review of the Wound Care assessment, completed by WCCNP #502 and dated [DATE] at 9:45 A.M., revealed Resident #34 was seen for a follow up visit for wound care services. The resident 's wound had declined. Treatment order changed to include applying hydrogel to wound bed to help absorb wound exudate along with alginate silver to prevent buildup of new bacteria. If dressing gets soiled, change as needed. The fully updated treatment order included cleanse wound with NS, pat dry, apply hydrogel followed by silver nitrate to the wound bed and cover with bordered foam dressing. Change/apply treatment daily and as needed. Interview on [DATE] at 11:18 A.M., with WCCNP #502 revealed Resident #34's sacral wound was worsening. WCCNP #502 confirmed sitting with stool on a wound would worsen the wound and could cause infection. WCCNP #502 revealed she assessed Resident #34 wounds weekly and had seen the resident frequently soiled with urine and stool. WCCNP #502 revealed she asked the staff to start cleaning residents prior to her visit. WCCNP #502 confirmed the STNAs should not be applying a new dressing or cleaning the wound and revealed she has seen dressings dated for days prior to when the wounds should have been changed. Review of the Wound Weekly Observation Tool dated [DATE] at 3:39 P.M. and completed by ADON #522, revealed Resident #34's wound to the sacrum was worsening with the wound having tunneling and/or undermining. The document included new treatment orders including to cleanse the coccyx wound with NS, apply hydrogel followed by silver alginate to the wound bed and cover with bordered foam dressing. Interview on [DATE] at 1:41 P.M. with ADON #522 stated she and WCCNP #502 had asked the STNAs to clean residents before rounds because they were frequently saturated with urine and/or stool. ADON #522 confirmed, during rounds, she had found wound dressings that were dated two or three days prior to when the wound treatments should have been done, which was daily. ADON #522 verified nurses were signing the wound care as completed on the TAR without completing treatments. ADON #522 revealed she talked to the nurses about it but hasn't had time to write them up yet. ADON #522 revealed the nurses were not completing their weekly skin assessments either. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the physician orders for Resident #34 revealed the order given by WCCNP #502 on [DATE] was not placed in the medical record and initiated until [DATE]. Review of the [DATE] TAR for Resident #34 confirmed the wound care treatment ordered on [DATE] was not initiated until [DATE]. Interview on [DATE] at 10:22 A.M. with the DON confirmed Resident #34 had overlapping wound care orders. The DON verified she did not know which treatments were completed for Resident #34. The DON confirmed old treatment orders should be discontinued when new orders were written. Interview on [DATE] at 11:04 A.M. with ADON #522 confirmed on [DATE] WCCNP #502 provided new treatment orders for Resident #34's sacral wound. ADON #522 verified the order was not placed in the resident's orders until [DATE] and not initiated until [DATE], stating she did not get to it because she had to work the floor. ADON #522 confirmed when new orders for treatments were written, the old wound care orders should be discontinued. ADON #522 confirmed when new wound treatment orders for Resident #34 were initiated [DATE], the previous order initiated [DATE] should have been discontinued and the wound care order dated [DATE] should have been discontinued on [DATE], when the new order started, resulting in overlapping orders and nurses signing the TAR as completing both treatments. ADON #522 could not confirm what wound care treatments Resident #34 received. 3) Review of Resident #40's medical record revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic kidney disease, overactive bladder, muscle weakness, and abnormalities of gait and mobility. Review of the quarterly MDS assessment dated [DATE] revealed Resident #40 was moderately cognitively impaired. Resident #40 was dependent for toileting, personal hygiene, and required substantial/maximum assistance with transfers. Resident #40 used a wheelchair and was dependent for mobility. Resident #40 was frequently incontinent of urine and occasionally incontinent of bowel. Resident #40 was at risk for pressure ulcers and had two stage three pressure ulcers. Resident #40 had a pressure reducing device to her chair. Review of the care plan, dated [DATE], revealed Resident #40 was at risk for alteration in elimination related to episodes of incontinence. Interventions included to check resident every two hours and assist with toileting as needed and monitor for skin redness and irritation and notify nursing. Resident #40 was also at risk for alteration in skin integrity related to impaired mobility, medication, episodes of incontinence and fragile skin. Interventions included turning and repositioning Resident #40 every two hours as tolerated. Review of Resident #40's [DATE] physician orders revealed the following orders: Initiated [DATE], Roho like cushion (pressure relieving) when up in wheelchair, check inflation every shift; initiated [DATE], wound care: cleanse right buttock wound with NS, pat dry, apply silver alginate to wound bed and apply foam dressing daily and as needed on day shift; initiated [DATE], wound care: cleanse right lower buttock abscess with NS daily and as needed, leave open to air scheduled every day shift; and initiated [DATE], encourage resident and assist to turn and reposition every two hours. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Wound Care note, dated [DATE] at 9:45 A.M. and completed by WCCNP #502, revealed Resident #40 had weakness with stiffness and limitation of movement. Upon examination the sacrum stage three pressure ulcer showed complete epithelization, healing was complete, and the wound was fully closed. The right lower buttocks wound (abscess) was slightly smaller in size, flat with a darkened discoloration and firm skin ridge/induration to the medial side of thigh. Orders included to cleanse wound with NS, pat dry to the wound bed, leave open to air and apply treatment daily and as needed. Review of the TAR for [DATE] through [DATE] revealed both orders for wound care to the right buttocks (cleanse right buttock wound w[TRUNCATED]		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, medical record review, staff interviews, and review of facility policy, the facility failed to ensure residents received timely incontinence care. This resulted in actual psychosocial harm when one resident (#40) was observed sitting in her wheelchair in her room. Resident #40 had a foul odor of urine and stool on her body, as well as her room. A blanket placed on the floor under Resident #40's wheelchair was saturated with urine, which was dripping onto the floor. Additionally, Resident #40 was wearing an adult brief and pull-up, both saturated in urine, as was a bed pad and blanket placed on the wheelchair seat under Resident #40. Resident #40 cried regarding the lack of incontinence care and stated it made her feel horrible. Furthermore, the facility failed to ensure timely incontinence care for two (#34 and #62) additional residents reviewed for incontinence care. Lastly, the facility failed to ensure catheter care and monitoring was provided for one (#98) of three residents reviewed for catheter care. The facility census was 86. Findings include: 1) Medical record review for Resident #40 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic kidney disease, overactive bladder, muscle weakness and abnormalities of gait and mobility. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was moderately cognitively impaired. Resident #40 was dependent for toileting, personal hygiene, and mobility and was frequently incontinent of urine and occasionally incontinent of bowel. Review of the care plan, dated 04/24/24, revealed Resident #40 was at risk for alteration in elimination related to episodes of incontinence and required assistance with toileting. Related diagnoses included overactive bladder and fluid overload. Interventions included to check Resident #40 every two hours and assist with toileting as needed. Observation on 06/03/24 at 10:56 A.M. revealed Resident #40 was sitting in her tilt-n-space wheelchair. Resident #40, and her room, had a strong, foul urine odor. The gown worn by Resident #40 was visibly saturated with urine. A white blanket observed under Resident #40's wheelchair was also visibly saturated with urine, which was dripping onto the floor. Concurrent interview with Resident #40 revealed she slept in her wheelchair and never got into bed. Resident #40 stated she had been asking for assistance with care, but staff had not been in to change her yet today. Interview on 06/03/24 at 10:59 A.M. with State tested Nurse Aide (STNA) #606 confirmed she was Resident #40's assigned STNA. STNA #606 stated she was busy but hoped to get to Resident #40 in about 20 minutes. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Observation on 06/03/24 at 11:32 A.M. of incontinence care provided by STNA #606 for Resident #40 revealed Resident #40 had a strong odor of urine on her body and in her room. Concurrent interview with STNA #606 verified the strong, foul odor of urine. STNA #606 stated, This is the first time I have been in here today, there is not enough staff. STNA #606 confirmed her shift began at 6:30 A.M. and she had not provided incontinence care for Resident #40 prior to this observation (five hours later). STNA #606 pushed Resident #40 in her wheelchair to the bathroom. STNA #606 confirmed the blanket on the floor under Resident #40's wheelchair was saturated with urine and the urine had dripped onto the floor. STNA #606 assisted Resident #40 to stand and the resident held onto the grab bar next to the toilet. The back and front of Resident #40's gown was saturated with urine. Resident #40 was sitting on a bath blanket covered by a pad that were both saturated in urine. STNA #606 removed the saturated bath blanket and pad and revealed the chair cushion underneath was also saturated in urine. STNA #606 removed two incontinent briefs, a pull up and an adult brief, from Resident #40. Both were saturated with urine and stool. Resident #40 had a wound dressing on her sacrum area which fell off when the second brief was removed due to saturation with urine and stool. Resident #40 began crying and stated, It makes me feel horrible, its bad. Resident #40 revealed she did not receive incontinence care very often. STNA #606 confirmed, at times, she could only change residents once a shift and, at most, twice during her eight-hour shift. STNA #606 verified the above observation and stated Resident #40 wore two briefs per her request. Resident #40, who was still crying, interjected and stated she requested two briefs because she did not get changed very often. STNA #606 completed incontinence care and washed Resident #40's upper body. STNA #606 applied a clean pull up and brief, placed a clean blanket and pad on top of the unwashed, urine saturated wheelchair cushion, and assisted Resident #40 back to her chair. STNA #606 stated it was a frequent occurrence for Resident #40 to be saturated with urine and stool. STNA #606 confirmed she did not clean Resident #40's wheelchair or cushion prior to assisting the resident back into it, stating she did not know how to. Interview on 06/05/24 at 11:18 A.M. with Wound Care Certified Nurse Practitioner (WCCNP) #502 revealed Resident #40 was completely saturated with urine, with the resident's brief falling off, when she visited earlier today. WCCNP #502 stated she visited residents weekly for wound care and frequently found residents, including Resident #40, saturated in urine and stool. WCCNP #502 revealed she started asking the STNAs to clean the residents up prior to being seen by her. Interview on 06/06/24 at 1:32 P.M. with Assistant Director of Nursing (ADON) #522 revealed she did wound rounds weekly with WCCNP #502. ADON #522 confirmed both WCCNP #502 and herself have asked the STNAs to clean the residents prior to wound care because they were frequently saturated with urine and or stool. 2) Medical record review for Resident #62 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, morbid obesity and acquired absence of right lower leg below the knee. Review of the quarterly MDS assessment dated [DATE] revealed Resident #62 was moderately cognitively impaired. Resident #62 was dependent for transfers, toileting, and required substantial/maximum assistance for personal hygiene. Resident #62 was frequently incontinent of bowel and bladder. Review of the care plan, dated 01/08/24, revealed Resident #62 had bowel incontinence. Interventions included checking the resident every two hours and assist with toileting as needed. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/03/24 at 10:05 A.M. with Resident #62 revealed she waited a long time to receive incontinence care, sometimes as long as 45 minutes after requesting assistance. Resident #62 stated no one would like to lay in a wet brief. Observation on 06/03/24 at 11:03 A.M. of incontinence care provided by STNA #605 for Resident #62 revealed the resident was lying in bed prior to care being provided. Resident #62 had two bed pads under her. Observation revealed both pads were wet with urine. STNA # 605 confirmed this was her first set of rounds for Resident #62, approximately 4.5 hours after her shift began at 6:30 A.M. STNA #605 stated there was not enough time to get to everyone. STNA #605 stated incontinence care should be provided at least every two hours and verified that did not occur. 3) Medical record review for Resident #34 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus with diabetic neuropathy and other skin ulcers, muscle weakness, acquired absence of right leg below the knee and need for assistants with personal care. Review of the quarterly MDS assessment dated [DATE] revealed Resident #34 was cognitively intact. Resident #34 was dependent for toileting, personal hygiene, and transfers. Resident #34 used a wheelchair, was dependent for mobility and was always incontinent of bowel and bladder. Review of the care plan, dated 07/21/23, revealed Resident #34 had bowel and bladder incontinence. Interventions included to check and change resident every two hours and as needed. Interview on 6/03/24 at 10:45 A.M. with Resident #34 revealed the last time incontinence care had been provided was around 4:00 A.M. Resident #34 revealed she needed care, but the STNAs did not have time. Resident #34 revealed she was frustrated but felt there was nothing she could do about it. Observation on 06/03/24 at 11:13 A.M. of incontinence care provided by STNA #460 for Resident #34 revealed the resident had a large bowel movement with stool dried on the resident's skin. STNA #460 confirmed this was the first time she had provided incontinence care for Resident #34 since the beginning of her shift, which began at 6:30 A.M. (nearly five hours later). STNA #460 stated there were not enough staff and too many residents who required total care. STNA #460 confirmed she was only able to provide incontinence care once per eight-hour shift, with some residents receiving care twice during her shift. STNA #460 stated she could not do it all. Interview on 06/05/24 at 11:18 A.M. with WCCNP #502 revealed she visited Resident #34 weekly, and the resident was frequently soiled with urine and stool. 4) Record review for Resident #98 revealed an admitted [DATE]. Diagnoses included fracture of other parts of pelvis, type two diabetes mellitus and presence of coronary angioplasty implant and graft. Further review of the medical record revealed no relevant diagnosis for the Foley catheter. Review of the Nursing Admit/Readmit assessment, dated 06/07/24 at 12:40 A.M. completed by LPN #634, revealed Resident #98 was admitted with hip and rib fractures. Resident #98 was alert to person, place, time and situation. Resident #98 was verbally appropriate, required extensive assistance with bed mobility, independent with eating and required extensive assistance with toilet use. Resident #98 had a catheter and was continent of stool. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan, dated 06/12/24, revealed Resident #98 had a Foley catheter. Interventions included monitoring intake and output as per facility protocol, monitor/record/report to physician (MD) signs and symptoms of a urinary tract infection (UTI), which included pain, no output and deepening of urine color. Review of Resident #98's physician orders revealed the following catheter care orders were entered on 06/11/24 (five days after admission): Foley output three times a day; Foley catheter to drainage bag, observe every shift; Foley catheter care every shift; and irrigate Foley with 50 cc if clogged or no urine output, if needed. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) from 06/06/24 through 06/13/24 at 6:00 A.M. revealed Foley catheter care was not initiated for Resident #98 until 06/11/24 (five days after admission) on the night shift. On 06/11/24, night shift, no Foley catheter output was documented. There was no documentation related to Foley catheter output on 06/12/24 or on 06/13/24 at 6:00 A.M. Interview on 06/12/24 at 10:09 A.M. with Resident #98 revealed the Foley catheter had been placed while he was in the hospital. Resident #98 stated he was continent of urine prior to placement of the catheter. Resident #98 stated the facility staff had never cleaned his peri area/catheter at the insertion site (catheter care). Interview on 06/12/24 at 10:23 A.M. with LPN #841 revealed the STNAs reported Resident #98's catheter was leaking earlier that shift. LPN #841 confirmed she had not assessed the resident yet and stated she was going to change the resident's Foley catheter. Further review of the medical record from 06/12/24 through 06/13/24 revealed no evidence LPN #841, or any other staff, provided care for Resident #98's leaking catheter. Interview on 06/12/24 at 1:42 P.M. with the DON confirmed Resident #98 did not have a diagnosis related to the Foley catheter, stating she did not know why the resident had a catheter. The DON verified Resident #98 did not have an initial care plan for the care of the Foley catheter and there were no physician orders placed for the care and treatment of the resident's catheter until 06/11/24 (five days after admission). The DON confirmed the need for the catheter should have been clarified on admission, as well as physician orders for catheter care. Additionally, the DON verified catheter care should be provided daily, beginning upon admission. The DON confirmed there was no evidence Resident #98 was provided catheter care from 06/06/24 through 06/12/24. Review of the facility policy titled Catheter Care, Urinary, revised September 2014, indicated the purpose of the procedure was to prevent catheter-associated urinary tract infections. Staff were to observe the resident's urine level for noticeable increases or decreases, maintain an accurate record of the resident's daily output and provide daily catheter care. This deficiency represents non-compliance investigated under Complaint Numbers OH00154761 and OH00153967.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to provide routine dressing changes to a central line for one (#62) of one resident reviewed for the care and treatment of a central line. The facility identified one resident with a central line. The facility census was 86. Findings include: Record review for Resident #62 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included type two diabetes mellitus and acquired absence of right lower leg below the knee. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was moderately cognitively impaired. Resident #62 had no impairment of the upper extremities and impairment on both sides of the lower extremities. Resident #62 required substantial/maximum assistance for personal hygiene and bed mobility. Resident #62 was at risk for pressure ulcers, had an unhealed pressure ulcer, one stage two and a diabetic foot ulcer, pressure reducing device to bed and chair, application of dressings, received no antibiotics and had no intravenous (IV) line. Review of Resident #62's care plan revealed no care plan was initiated for a central line (an IV line much larger than a regular IV in which a patient can receive medicine, fluids, blood or nutrition through). Review of Resident #62's physician orders revealed an order initiated on 11/30/24 and discontinued on 01/11/24 to change dressing to central line in right chest every week on Monday and as needed and change needless device every week on Monday add as needed after lab draws. Further review of Resident #62's physician orders from 01/11/24 through 06/03/24 revealed no active orders for the central line dressing changes or needless device changes. Observation on 06/03/24 at 10:05 A.M. of Resident #62 revealed the resident had a central line located in the right upper chest. A clear dressing was covering the central line. The lower portion of the dressing was lifted, exposing the insertion site to the elements. The dressing was dated 05/12/24. Concurrent interview with Resident #62 revealed she was unsure when staff last changed the dressing to the central line site. Interview on 06/03/24 at 12:12 P.M. with Registered Nurse (RN) #909 verified Resident #62's central line dressing had not been changed since 05/12/24. Additionally, RN #909 confirmed the lower portion of the dressing was lifted, exposing the insertion site. RN #909 confirmed the dressing to the insertion site should be changed weekly and as needed. Interview on 06/05/24 at 12:35 P.M. with the Director of Nursing (DON) verified there was no order for changing Resident #62's central line dressing or needless device. The DON confirmed both the dressing and the needless device should be changed weekly and as needed to prevent infection and further verified it was not done. The DON stated Resident #62's central line was inserted at the hospital on 11/29/23. The DON confirmed confirmed no nursing plan of care had been developed for Resident #62's central line. The DON stated the central line was used for the administration of IV antibiotics. (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/20/24 at 9:15 A.M. with Assistant Director of Nursing (ADON) #522 revealed Resident #62 was in the hospital from 01/11/24 until 01/14/24. ADON #522 stated upon the resident's return, nursing staff should have restarted the orders for the central line dressing changes and the needless device to be changed weekly and as needed. ADON #522 verified there were no orders for the care of Resident #62's central line from 01/14/24 until 06/04/24 when brought to their attention by the surveyor. ADON #522 stated this was a nursing error and nurses were supposed to make sure those orders were in the system to ensure they see when the dressings are to be done. Review of the facility policy titled Central Venous Catheter Dressing Changes, revised April 2016, revealed the purpose of the procedure was to prevent catheter related infections that are associated with contaminated, loosened, soiled, or wet dressings. General guidelines included to change transparent semi-permeable dressing at least every five to seven days and when needed when wet, soiled or not intact. This was an incidental finding discovered during the complaint investigation.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, resident interview, staff interview, medical record review and review of the facility assessment to provide competent support and care for the resident population, the facility failed to ensure sufficient staff to meet the individualized needs of each specific resident. This affected three (#62, #40 and #34) of three residents reviewed for staffing. Additionally, the remaining 83 residents residing in the facility were placed at potential risk for not having their individualized needs met based on insufficient staffing resources necessary to provide competent support and care for the resident population. The facility census was 86. Findings include: 1. Record review for Resident #62 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, morbid obesity, and acquired absence of right lower leg below the knee. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was moderately cognitively impaired. Resident #62 was dependent for transfers, toileting, and required substantial/maximum assistance for personal hygiene. Resident #62 was frequently incontinent of bowel and bladder. Review of the care plan dated 01/08/24 revealed Resident #62 had bowel incontinence. Interventions included checking resident every two hours and assist with toileting as needed. Interview on 06/03/24 at 9:49 A.M. with State tested Nursing Assistant (STNA) #911 revealed there were many residents who required a lot of care and residents had to wait a long time to get incontinence care. Interview on 06/03/24 at 9:55 A.M. with Licensed Practical Nurse (LPN) #613 revealed residents were not provided timely incontinence care, stating it was a struggle and residents' basic needs were not getting met. Interview on 06/03/24 at 10:05 A.M. with Resident #62 revealed she did not receive timely incontinence care and frequently had to wait a long time. Resident #62 stated no one would like to lay in a wet brief. Observation on 06/03/24 at 11:03 A.M. of incontinence care provided by STNA #605 for Resident #62 revealed the resident was wearing an adult brief and had two bed pads under her. The brief and both pads were wet with urine. STNA # 605 stated this was her first set of rounds to provide incontinence care on her shift, which began at 6:30 A.M. (nearly 4.5 hours earlier). STNA #605 confirmed Resident #62 preferred to get out of bed earlier in the day but stated there was just not enough time to get to everyone. STNA #605 confirmed rounds should be completed every two hours and verified this did not happen. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Record review for Resident #40 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic kidney disease, overactive bladder, muscle weakness and abnormalities of gait and mobility. Review of the quarterly MDS assessment dated [DATE] revealed Resident #40 was moderately cognitively impaired. Resident #40 was dependent for toileting, personal hygiene, and mobility. Resident #40 was frequently incontinent of urine and occasionally incontinent of bowel. Review of the care plan dated 04/24/24 revealed Resident #40 was at risk for alteration in elimination related to episodes of incontinence and required assistance with toileting with related diagnoses being overactive bladder and fluid overload. Interventions included to check Resident #40 every two hours and assist with toileting as needed. Observation on 06/03/24 at 10:56 A.M. revealed Resident #40 was sitting up in her tilt n space chair. Resident #40's body and her room had a strong, foul odor of urine. Concurrent interview with Resident #40 revealed did not sleep in a bed and stayed in her wheelchair at all time because staff did not get her up. Resident #40 was wearing a gown that was visibly saturated with urine. A white blanket under her wheelchair was also visually saturated with urine. Resident #40 revealed she had been asking to get changed but no one had provided incontinence care for her yet today. Interview on 06/03/24 at 10:59 A.M. with State tested Nursing Assistant (STNA) #606 confirmed she was Resident #40's assigned STNA. STNA #606 revealed she was busy caring for other residents but was hoping to get to Resident #40 in about 20 minutes. Observation on 06/03/24 at 11:32 A.M. of incontinence care provided by STNA #606 for Resident #40 revealed Resident #40 had a strong odor of urine on her body and in her room. Concurrent interview with STNA #606 verified the strong foul odor of urine. STNA #606 stated, This is the first time I have been in here today. There is not enough staff. STNA #606 confirmed her shift began at 6:30 A.M. (five hours earlier). Continued observation revealed Resident #40 was saturated with urine, which STNA #606 verified. STNA #606 revealed, at times, she could only change residents once a shift and, at the most, twice during her eight hour shift. STNA #606 revealed Resident #40 wore two adult briefs, per her preference. Resident #40 interjected and stated she requested two briefs because she did not get changed very much. Interview on 06/05/24 at 11:18 A.M. with Wound Care Certified Nurse Practitioner (WCCNP) #502 revealed when she visited Resident #40 earlier this day, Resident #40 was completely saturated in urine with her brief falling off her. WCCNP #502 revealed she visited residents weekly for wound care and frequently found residents, including Resident #40, saturated in urine and stool. Interview on 06/06/24 at 1:32 P.M. with Assistant Director of Nursing (ADON) #522 revealed she did wound rounds weekly with WCCNP #502. ADON #522 confirmed both WCCNP #502 and herself have had to ask the STNA's to clean the residents before they went in because they were frequently saturated with urine and/or stool. 3. Record review for Resident #34 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus with diabetic neuropathy and other skin ulcer, muscle weakness, acquired absence of right leg below the knee and need for assistants with personal care. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Wesleyan Village		STREET ADDRESS, CITY, STATE, ZIP CODE 807 West Ave Elyria, OH 44035	
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the quarterly MDS assessment dated [DATE] revealed Resident #34 was cognitively intact. Resident #34 was dependent for toileting, personal hygiene, and transfers. Resident #34 used a wheelchair and was dependent for mobility. Resident #34 was always incontinent of bowel and bladder. Review of the care plan dated 07/21/23 revealed Resident #34 had bowel and bladder incontinence. Interventions included to check and change resident every two hours and as needed. Interview on 6/03/24 at 10:45 A.M. with Resident #34 revealed she wanted to get out of bed to either sit on the edge of her bed or the chair, but the STNA's often told her they did not have time or they could come, which was sometimes one to one and a half hours later. Resident #34 revealed the last time the STNA provided incontinence care was 4:00 A.M. Resident #34 revealed she needed care now, but the STNA's did not have time. Resident #34 revealed she was frustrated but felt there was nothing she could do about it. Observation on 06/03/24 at 11:13 A.M. of incontinence care provided by STNA #460 for Resident #34 revealed the resident had large bowel movement. The stool was partially dried on Resident #34's skin. STNA #460 revealed this was the first time she was able to assist Resident #34 with incontinence care since the beginning of her shift at 6:30 A.M. (nearly five hours earlier). STNA #460 confirmed Resident #34 sometimes requested to get out of bed but there was just not enough help to assist her. STNA #460 stated there was not enough staff and too many residents who required total care. STNA #460 revealed residents were usually provided incontinence care at least once per shift, some were changed twice per shift, and expressed she could not do it all. Interview on 06/03/24 at 11:29 A.M. with Scheduler #515 confirmed she scheduled all staff daily. The second floor was to have two STNAs per shift, the third floor was to have three STNAs per shift and the fourth floor was to have two STNAs per shift. Scheduler #515 confirmed the facility was fully staffed today. Interviews on 06/03/24 between 1:57 P.M. and 4:02 P.M. with STNA #607, STNA #608, STNA #622, STNA #673, STNA #912 and STNA #913 revealed there was not enough staff to meet the residents' needs, including incontinence care. The STNAs stated there were times when residents only received incontinence care once during an eight hour shift and residents were not getting up and going to bed when requested. STNA #913 revealed she spoke to the Director of Nursing (DON) about staffing but nothing changed. Interview on 06/03/24 at 4:49 P.M. with the Director of Nursing (DON) confirmed staff expressed to her they were having a hard time completing tasks timely, even when fully staffed. The DON revealed each resident should be checked every two hours for incontinence and provided care when needed. The DON confirmed residents should be assisted to get out of bed and go to bed when they wanted. Interview on 06/06/24 at 2:44 P.M. with the Administrator revealed staff always say they wish they had more staff, all the time. The Administrator stated they just say we want more staff but never give details. (continued on next page)		

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 06/06/24 at 3:10 P.M. with Assistant Administrator (AA) #523 revealed the current Administrator left for two months then recently returned. During the time she was gone, she covered as the Administrator. AA #523 confirmed staff expressed staffing concerns to her, especially the third floor, but when they had more staff, work was still not being done, it was just constant complaining. Review of the facility assessment updated 06/03/24 revealed the staffing plan was for the second floor to have two aids and on nurse all shifts. The third floor was to have three aids all shifts and two nurses. The fourth floor was to have two aids and on nurse all shifts. Follow-up interview on 06/20/24 at 6:30 P.M. with Administrator confirmed the staffing number documented in the facility assessment did not provide adequate competent staff to meet the care needs of the residents residing at the facility. This deficiency represents non-compliance investigated under Complaint Number OH00154761, OH00153885, OH00153900, and OH00153215.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, resident interview, staff interview and review of the facility assessment, the facility failed to accurately assess and identify the needed competent nursing staff resources, based on resident acuity, to meet the individualized needs of specific residents. This affected three (#62, #40 and #34) of three residents reviewed for staffing with the potential to affect the remaining 83 residents residing in the facility who required nursing staff to meet their care needs. The facility census was 86. Findings include: 1. Record review for Resident #62 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, morbid obesity, and acquired absence of right lower leg below the knee. Further review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was dependent for transfers, toileting, and required substantial/maximum assistance for personal hygiene. Resident #62 was frequently incontinent of bowel and bladder. Review of the care plan dated 01/08/24 revealed Resident #62 had bowel incontinence. Interventions included checking resident every two hours and assist with toileting as needed. Interview on 06/03/24 at 9:49 A.M. with State tested Nursing Assistant (STNA) #911 revealed there were many residents who required a lot of care and residents had to wait a long time to get incontinence care. Interview on 06/03/24 at 9:55 A.M. with Licensed Practical Nurse (LPN) #613 revealed residents were not provided timely incontinence care, stating it was a struggle and residents' basic needs were not being met. Interview on 06/03/24 at 10:05 A.M. with Resident #62 revealed she did not receive timely incontinence care and frequently had to wait a long time. Resident #62 stated no one would like to lay in a wet brief. Observation on 06/03/24 at 11:03 A.M. of incontinence care provided by STNA #605 for Resident #62 revealed the resident was wearing and adult brief and had two bed pads under her. The brief and both pads were wet with urine. STNA # 605 stated this was her first set of rounds to provide incontinence care on her shift, which began at 6:30 A.M. (nearly 4.5 after her shift started). STNA #605 confirmed Resident #62 preferred to get out of bed earlier in the day but stated there was just not enough time to get to everyone. STNA #605 confirmed rounds should be completed every two hours and verified this did not happen. 2. Record review for Resident #40 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic kidney disease, overactive bladder, muscle weakness and abnormalities of gait and mobility. Further review of the quarterly MDS assessment dated [DATE] revealed Resident #40 was dependent for toileting, personal hygiene, and mobility. Resident #40 was frequently incontinent of urine and occasionally incontinent of bowel. (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the care plan dated 04/24/24 revealed Resident #40 was at risk for alteration in elimination related to episodes of incontinence and required assistance with toileting with related diagnoses being overactive bladder and fluid overload. Interventions included to check Resident #40 every two hours and assist with toileting as needed. Observation on 06/03/24 at 10:56 A.M. revealed Resident #40's body and room had a strong, foul urine odor. Concurrent interview with Resident #40 revealed did not sleep in a bed and stayed in her wheelchair at all time because staff did not get her up. Resident #40's gown and a white blanket under her wheelchair were visibly saturated with urine. Resident #40 revealed she had been asking to get changed but no one had provided incontinence care for her yet today. Interview on 06/03/24 at 10:59 A.M. with State tested Nursing Assistant (STNA) #606 confirmed she was Resident #40's assigned STNA. STNA #606 revealed she was busy caring for other residents but was hoping to get to Resident #40 in about 20 minutes. Observation on 06/03/24 at 11:32 A.M. of incontinence care provided by STNA #606 for Resident #40 confirmed Resident #40 was saturated with urine. During a concurrent interview with STNA #606, the STNA stated, This is the first time I have been in here today. There is not enough staff. STNA #606 confirmed her shift began at 6:30 A.M. (five hours earlier). STNA #606 revealed, at times, she could only change residents once a shift and, at the most, twice during her eight hour shift. STNA #606 revealed Resident #40 wore two adult briefs, per her preference. Resident #40 interjected and stated she requested two briefs because she did not get changed very much. 3. Record review for Resident #34 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus with diabetic neuropathy and other skin ulcer, muscle weakness, acquired absence of right leg below the knee and need for assistants with personal care. Further review of the quarterly MDS assessment dated [DATE] revealed Resident #34 was dependent for toileting, personal hygiene, and transfers. Resident #34 used a wheelchair and was dependent for mobility. Resident #34 was always incontinent of bowel and bladder. Review of the care plan dated 07/21/23 revealed Resident #34 had bowel and bladder incontinence. Interventions included to check and change resident every two hours and as needed. Interview on 6/03/24 at 10:45 A.M. with Resident #34 revealed she wanted to get out of bed to either sit on the edge of her bed or the chair, but the STNA's often told her they did not have time or they could come, which was sometimes one to one and a half hours later. Resident #34 revealed the last time the STNA provided incontinence care was at 4:00 A.M. Resident #34 revealed she needed care now, but the STNA's did not have time. Resident #34 revealed she was frustrated but felt there was nothing she could do about it. Observation on 06/03/24 at 11:13 A.M. of incontinence care provided by STNA #460 for Resident #34 revealed the resident had stool partially dried on the resident's skin. STNA #460 revealed this was the first time she was able to assist Resident #34 with incontinence care since the beginning of her shift at 6:30 A.M. (five hours after her shift began). STNA #460 confirmed Resident #34 sometimes requested to get out of bed but there was just not enough help to assist her. STNA #460 stated there was not enough staff and too many residents who required total care. STNA #460 revealed residents were usually provided incontinence care at least once per shift, some were changed twice per shift, and expressed she could not do it all. STNA #460 confirmed she worked eight hour shifts. (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 06/03/24 at 11:29 A.M. with Scheduler #515 confirmed she scheduled all staff daily. The second floor was to have two STNAs per shift, the third floor was to have three STNAs per shift and the fourth floor was to have two STNAs per shift. Scheduler #515 confirmed the facility was fully staffed today. Interviews on 06/03/24 between 1:57 P.M. and 4:02 P.M. with STNA #607, STNA #608, STNA #622, STNA #673, STNA #912 and STNA #913 revealed there was not enough staff to meet the residents' needs. The STNAs stated there were times when residents only received incontinence care once during an eight hour shift and residents were not getting up and going to bed when requested. STNA #913 revealed she spoke to the Director of Nursing (DON) about staffing but nothing changed. Interview on 06/03/24 at 4:49 P.M. with the DON confirmed staff expressed to her they were having a hard time completing tasks timely, even when fully staffed. The DON revealed each resident should be checked every two hours for incontinence and provided care when needed. The DON confirmed residents should be assisted to get out of bed and go to bed when they wanted. Interview on 06/06/24 at 2:44 P.M. with the Administrator revealed staff always say they wish they had more staff, all the time. The Administrator stated they just say we want more staff but never give details. Interview on 06/06/24 at 3:10 P.M. with Assistant Administrator (AA) #523 revealed the current Administrator left for two months then recently returned. During the time she was gone she covered as the Administrator. AA #523 confirmed staff expressed to her staffing concerns, especially the third floor, but when they had more staff, work was still not being done, it was just constant complaining. Review of the facility assessment updated 06/03/24 revealed the staffing plan was for the second floor to have two aids and on nurse all shifts. The third floor was to have three aids all shifts and two nurses. The fourth floor was to have two aids and on nurse all shifts. Follow-up interview on 06/20/24 at 6:30 P.M. with the Administrator confirmed the staffing number documented in the facility assessment did not accurately reflect the acuity of the facility's residents and did not provide adequate competent nursing staff to meet the individualized care needs of each specific resident.		