

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 08/26/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on medical record review, review of shower schedules, and staff interview, the facility failed to ensure residents were provided adequate bathing as scheduled. This affected three (#212, #277, and #300) of three residents reviewed for activities of daily living. The facility census was 82. Findings include: 1. Review of the medical record for Resident #212 revealed an admitted [DATE]. Diagnoses include generalized weakness, hypertension, Alzheimer's dementia, depression, and elevated cholesterol. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #212 was assessed as severely cognitively impaired and required substantial/maximal assistance with showering and bathing as well as hygiene. Review of facility shower schedule revealed Resident #212 was scheduled for showers/baths every Monday and Friday on day shift. Review of the facility shower schedule for 06/01/24 through 08/26/24 revealed Resident #212 was scheduled to receive 25 showers/baths. Review of facility shower documentation revealed Resident #212 received showers/baths on 06/06/24, 06/17/24, 07/01/24, 07/05/24, 07/10/24, 07/15/24, 08/09/24, and 08/17/24. Further review of Resident #212's medical record revealed the resident was in the hospital on 06/21/24. 2. Review of the medical record for Resident #277 revealed an admitted [DATE]. Diagnoses include seizures, asthma, generalized muscle weakness, abnormalities of gait and mobility, need for assistance with personal care, major depressive disorder, anxiety disorder, and hypertension. Review of the annual MDS assessment dated [DATE] revealed Resident #277 was assessed as cognitively intact and required substantial/maximal assistance with showers/baths as well as hygiene. Review of the facility shower schedule revealed Resident #277 was scheduled for showers/baths every Monday and Thursday in the evening. Review of the facility shower schedule for 06/01/24 through 08/26/24 revealed Resident #277 was scheduled to receive 25 showers/baths. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility shower documentation revealed Resident #277 received showers/baths on 06/06/24, 06/20/24, 06/21/24, 06/27/24, 07/18/24, 07/25/24, 07/29/24, 08/01/24, 08/05/24, 08/12/24, 08/15/24, and was bathed twice on 08/19/24. 3. Review of the medical records for Resident #300 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses include end stage renal disease, displaced comminuted fracture of the left femur, mild protein-calorie malnutrition, type II diabetes mellitus, chronic obstructive pulmonary disease, generalized muscle weakness, other abnormalities of gait and mobility, hypoglycemia, and need for assistance with personal care. Review of the quarterly MDS assessment dated [DATE] revealed Resident #300 was dependent for showers/baths and hygiene. Review of the facility shower schedule revealed Resident #300 was scheduled for showers/baths every Monday and Thursday in the evening. Review of the facility shower schedule for 06/01/24 through 08/01/24 revealed Resident #300 was scheduled to receive 18 showers/baths. Review of facility shower documentation revealed Resident #300 received a showers/bath on 06/06/24 and refused a shower/bath on 06/27/24. Interview on 08/26/24 at 2:08 P.M. with the Regional Director of Clinical Services (RDCS), the Administrator, the Director of Nursing (DON), and the Regional Director of Operations (RDO) confirmed Resident #212, Resident #277, and Resident #300 were not bathed as scheduled and stated there was no further documentation of the residents being provided adequate bathing as scheduled. This deficiency represents non-compliance investigated under Complaint Number OH00156525.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, medical record review, staff interview, and review of a facility investigation, the facility failed to ensure a resident assessed and care planned for elopement was provided with adequate supervision to prevent elopement. This affected one (#212) out of three residents reviewed for elopements. The facility census was 82. Findings include: Review of the medical record for Resident #212 revealed an admitted [DATE]. Diagnoses include generalized weakness, hypertension, Alzheimer's dementia, depression, and elevated cholesterol. Review of a care plan dated 03/29/24 revealed Resident #212 was care planned at risk for elopement as the resident wandered aimlessly. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #212 was assessed as severely cognitively impaired and was independently ambulatory. Review of an elopement risk assessment dated [DATE] revealed Resident #212 was assessed at high risk for elopement. Review of an investigation dated 08/17/24 revealed Resident #212 was found on the second floor roof of the facility and brought back inside by staff without incident. Interview on 08/22/24 at 9:12 A.M. with State tested Nurse Aide (STNA) #53 revealed Resident #212 was able to push the window open to get on the roof from her room. Interview on 08/22/24 at 9:25 A.M. with the Director of Nursing (DON) revealed Resident #212 was on the roof for less than five minutes. Interview on 08/22/24 at 11:14 A.M. with STNA #7 revealed staff was in the medication administration room on the facility's third floor when they observed Resident #212 on the roof of the facility. STNA #7 stated staff immediately ran down the facility steps, went to Resident #212's room, exited the window, and aided Resident #212 back into the facility without incident. STNA #7 revealed Resident #212 utilized a spoon from a meal tray to remove the screen from the window and then pushed on the window to open it enough for the resident to elope from their room onto the facility roof. STNA #7 stated Resident #212 was found on the part of the roof with rocks and was sitting with her back against the wall in the corner. Observation on 08/22/24 at approximately 11:30 A.M. revealed Resident #212's window exited onto a flat roof covered in rocks. In front of the roof covered in rocks was a roof that had a slight peak and immediately on the other side of that roof peak was the area that Resident #212 was found. The roof had a parapet wall that was identified where the resident was found sitting on the corner of. This deficiency represents non-compliance investigated under Complaint Number OH00156962.		