

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 12/11/2024
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure resident weights were obtained and monitored in accordance with physician orders, dietitian recommendations, and the plan of care. This affected two (#4 and #15) of three residents reviewed for weights. The facility census was 84. 1. Review of the medical record revealed Resident #4 was initially admitted to the facility on [DATE]. The resident discharged to the hospital on 10/23/24 and readmitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, muscle weakness, need for assistance with personal care, hypertension, chronic kidney disease, anxiety, and depression. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was cognitively intact. Review of the current physician orders for Resident #4 identified an order dated 10/30/24 for weekly weights for four weeks and then monthly. Review of the plan of care dated 10/31/24 revealed Resident #4 was at nutritional risk related to diagnoses, recent surgery, and therapeutic diet restrictions. Interventions included monitoring the resident's weight per policy and monitoring the need for further nutritional interventions. Review of the weight record revealed Resident #4's weight was last obtained on 10/20/24 and was not obtained again until 12/04/24. An interview on 12/04/24 at 10:44 A.M. with Licensed Practical Nurse (LPN) #970 verified Resident #4's weight had not been obtained per physician order. An interview on 12/05/24 at 11:26 A.M. with Regional Director of Clinical Operations #994 also verified the weekly weights for Resident #4 were not obtained per physician order. 2. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, chronic kidney disease, muscle weakness, and hypertension. Review of the Significant Change MDS assessment dated [DATE] identified Resident #15 was cognitively impaired. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 365162	If continuation sheet Page 1 of 10

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 11/18/23, and revised 10/18/24, revealed Resident #15 had a nutritional problem or potential nutritional problems related to therapeutic diet restrictions and insulin. Interventions included monitoring, recording, and reporting signs and symptoms of malnutrition including significant weight loss, and evaluating and making diet change recommendations as needed. Review of the nutritional assessment dated [DATE] revealed Resident #15 was at risk for malnutrition. The resident's weight was to be maintained with no significant changes and a new order for weekly weights for four weeks was recommended. Review of the weight record revealed Resident #15's weight was obtained on 07/10/24 and was not obtained again until 08/20/24. An interview on 12/05/24 at 11:26 A.M. with Regional Director of Clinical Operations #994 verified the weekly weights for Resident #15 were not obtained per the dietitian recommendations/orders. Review of the facility policy titled, Weight Assessment and Intervention, dated 01/10/23, revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for residents. In addition, monthly weights would be completed by the tenth of each month, and weekly weights would be completed on a designated day each week. This deficiency represents non-compliance investigated under Complaint Number OH00159400.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44454 Based on medical record review, resident and staff interview, and review of the facility policy, the facility failed to have sufficient staffing to meet the care needs of all residents. This directly affected three (#4, #15, and #16) of five residents reviewed for staffing and had the potential to affect 18 (#5, #8, #12, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, and #45) additional residents residing on the fourth floor. The facility census was 84. Findings include: 1. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, muscle weakness, need for assistance with personal care, hypertension, chronic kidney disease, anxiety, and depression. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was cognitively intact. Review of the current physician orders for Resident #4 identified an order dated 09/22/24 for insulin lispro 100 units per milliliter solution with instructions to inject per sliding scale before meals up to 10 units per dose. The resident also had an order dated 10/30/24 for weekly weights for four weeks and then monthly. Review of the medication administration record (MAR) for October 2024 revealed Resident #4's blood glucose level was not documented as obtained before the lunch meal on 10/11/24 and on 10/20/24. Review of the nursing progress notes dated 10/11/24 and timed 5:37 P.M. revealed Resident #4's blood glucose level was not obtained. Review of the nursing progress notes dated 10/20/24 and timed 3:39 P.M. revealed Resident #4's blood glucose level was not obtained. Review of the weight record revealed Resident #4's weight was last obtained on 10/20/24 and was not obtained again until 12/04/24. There was no documentation indicating weekly weights were obtained in accordance with physician orders. Interview on 12/04/24 at 10:44 A.M. with Licensed Practical Nurse (LPN) #970 verified Resident #4's weight not was obtained per physician order between 10/30/24 and 12/04/24. An interview on 12/09/24 at 12:00 P.M. with LPN #802 verified Resident #4's blood glucose level was not obtained as ordered on 10/11/24 and 10/20/24. LPN #802 reported it was due to insufficient staffing. LPN #802 stated by the time they were able to get to Resident #4, the resident's next blood glucose level check was due. LPN #802 also reported staff were often unable to obtain resident weights due to insufficient staffing. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/05/24 at 2:10 P.M. with Resident #4 revealed there were not enough staff to meet his needs. 2. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, chronic kidney disease, muscle weakness, and hypertension. Review of the nutritional assessment dated [DATE] revealed Resident #15 was at risk for malnutrition. The resident's weight was to be maintained with no significant changes and a new order for weekly weights for four weeks was recommended. Review of the weight record revealed Resident #15's weight was obtained on 07/10/24 and was not obtained again until 08/20/24. There was no documentation indicating weekly weights were obtained in accordance with physician orders. An interview on 12/05/24 at 11:26 A.M. with Regional Director of Clinical Operations #994 verified the weekly weights for Resident #15 were not obtained per the dietitian recommendations. Interview on 12/04/24 at 11:17 A.M. with LPN #642 stated resident weights were often not obtained due to insufficient staffing. LPN #642 reported weights were often not obtained due to staff attempting to focus on the more immediate needs of the residents. Review of the facility policy titled, Weight Assessment and Intervention, dated 01/10/23, revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for residents. In addition, monthly weights would be completed by the tenth of each month, and weekly weights would be completed on a designated day each week. 3. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included rheumatoid arthritis, pain in right shoulder, pain in left shoulder, chronic pain syndrome, peripheral vascular disease, muscle weakness, need for assistance with personal care, and heart failure. Review of the quarterly MDS assessment dated [DATE] identified Resident #16 was cognitively intact. Review of the plan of care dated 10/23/24 identified Resident #16 had chronic pain related to arthritis and peripheral vascular disease. Interventions included administering pain medication as ordered. Review of the current physician orders for Resident #16 identified an order dated 07/16/24 for Lac-hydrin 12 percent (%) external lotion with instructions to apply to the soles of the feet topically every morning and at bedtime. Further review of the current physician orders for Resident #16 identified an order dated 07/28/24 for the pain medication gabapentin oral capsule 300 milligrams (mg) by mouth every morning and at bedtime for neuropathy, and an order dated 09/18/24 for the narcotic pain medication Ultram oral capsule 50 mg by mouth every morning and at bedtime for pain. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MAR for October 2024 revealed on 10/11/24 the Lac-hydrin lotion was not administered on the mornings of 10/10/24, 10/11/24, 10/20/24, and 10/28/24. Further review of the MAR for October 2024 revealed on 10/11/24 the morning doses of Ultram and gabapentin were not documented as administered and were coded with a 9. In addition, on 10/19/24, the morning dose of gabapentin was not documented as administered and was coded with a 9. Review of the nursing progress notes dated 10/11/24 and timed 7:09 P.M. revealed Resident #16's Ultram and gabapentin were not administered due to timing. Review of the nursing progress notes dated 10/19/24 and timed 2:43 P.M. revealed Resident #16's gabapentin was not administered due to a time constraint. Interview on 12/04/24 at 12:24 P.M. with Resident #16 revealed the resident did not always receive medications as ordered and often had to wait long periods of time for staff assistance. An interview on 12/09/24 at 12:00 P.M. with LPN #802 verified Resident #16's lotion was not applied as ordered on the above mentioned dates. LPN #802 also confirmed Resident #16's Ultram was not administered as ordered on 10/11/24 and confirmed gabapentin was not administered on 10/11/24 and 10/19/24 as ordered. LPN #802 verified staff were unable to administer medications within the prescribed timeframes due to staffing, and therefore did not administer medications. Review of the facility policy titled, Administering Medications, revised December 2012, revealed medications shall be administered in a safe and timely manner, and as prescribed. In addition, the policy revealed medications must be administered in accordance with the orders, including any required time frame. Review of the facility policy titled, Staffing, revised April 2007, revealed the facility would provide adequate staffing to meet needed care and services for their resident population. This deficiency represents non-compliance investigated under Master Complaint Number OH00159786, Complaint Master Number OH00159769, Complaint Number OH00159718, Complaint Number OH00159400, and Complaint Number OH00159147.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to administer medications in accordance with physician orders. This affected two (#6 and #16) of four residents reviewed for medication administration. Findings include. 1. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE]. The resident discharged on [DATE]. Diagnoses included type II diabetes mellitus, muscle weakness, unspecified age-related cataracts, and heart failure. Review of physician orders identified an order dated 09/27/24 for Olopatadine solution 0.2 percent (%) with instructions to instill one drop in both eyes one time per day for dry eyes. Review of the medication administration record (MAR) for Resident #6 revealed the eye drops were not administered on 09/27/24, 09/28/24, 09/29/24, 09/30/24, 10/01/24, 10/02/24, 10/05/24, 10/06/24, 10/10/24, 10/11/24, and 10/25/24. An interview on 12/09/24 at 2:56 P.M. with Regional Director of Clinical Operations #994 verified staff likely could not locate the eye drops and therefore did not administer them. Regional Director of Clinical Operations #994 verified there was no documentation Resident #6 received eye drops as ordered on the dates listed above. 2. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included rheumatoid arthritis, pain in right shoulder, pain in left shoulder, chronic pain syndrome, peripheral vascular disease, muscle weakness, need for assistance with personal care, and heart failure. Review of the quarterly Minimum Data Set assessment dated [DATE] identified Resident #16 was cognitively intact. Review of the current physician orders for Resident #16 identified an order dated 07/16/24 for Lac-hydrin 12% external lotion with instructions to apply to the soles of the feet topically every morning and at bedtime. Review of the MAR for October 2024 revealed on 10/11/24 the Lac-hydrin lotion was not administered on the mornings of 10/10/24, 10/11/24, 10/20/24, and 10/28/24. An interview on 12/04/24 at 12:24 P.M. with Resident #16 revealed the resident sometimes did not receive medications including lotion. An interview on 12/09/24 at 12:00 P.M. with Licensed Practical Nurse #802 verified Resident #16's lotion was not applied as ordered on the above mentioned dates. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Administering Medications, revised December 2012, revealed medications shall be administered in a safe and timely manner, and as prescribed. In addition, the policy revealed medications must be administered in accordance with the orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number OH00159718.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review and staff interview, the facility failed to adequately monitor resident blood glucose levels for sliding scale insulin as ordered. This affected one (#4) of three residents reviewed for insulin administration. The facility census was 84. Findings include: Review of the medical record revealed Resident #4 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, muscle weakness, need for assistance with personal care, hypertension, chronic kidney disease, anxiety, and depression. Review of the current physician orders for Resident #4 identified an order dated 09/22/24 for insulin lispro 100 units per milliliter solution with instructions to inject the insulin per sliding scale before meals up to 10 units per dose. Review of the plan of care dated 10/31/24 revealed Resident #4 had a history of type II diabetes mellitus. Interventions included Accu-checks (blood glucose level monitoring) as ordered, administering medications as ordered, and monitoring blood glucose levels-covering abnormal levels per sliding scale ordered by physician. Review of the medication administration record (MAR) for October 2024 revealed Resident #4's blood glucose level was not documented as obtained before the lunch meal on 10/11/24 and 10/20/24. Review of the nursing progress notes dated 10/11/24 and timed 5:37 P.M. revealed Resident #4's blood glucose level was not obtained. Review of the nursing progress notes dated 10/20/24 and timed 3:39 P.M. revealed Resident #4's blood glucose level was not obtained. An interview on 12/09/24 at 12:00 P.M. with Licensed Practical Nurse #802 verified Resident #4's blood glucose levels were not obtained as ordered on 10/11/24 and 10/20/24 and therefore, there was no way to know how much insulin was supposed to be administered or if the insulin would have not been given. This deficiency represents non-compliance investigated under Complaint Number OH00159718.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, resident and staff interview, and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected one (#16) of four residents reviewed for medication administration. The facility census was 84. Findings include: Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included rheumatoid arthritis, pain in right shoulder, pain in left shoulder, chronic pain syndrome, peripheral vascular disease, muscle weakness, need for assistance with personal care, and heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #16 was cognitively intact. Review of the plan of care dated 10/23/24 identified Resident #16 had chronic pain related to arthritis and peripheral vascular disease. Interventions included administering pain medication as ordered. Review of the current physician orders for Resident #16 identified an order dated 07/28/24 for the pain medication gabapentin oral capsule 300 milligrams (mg) by mouth every morning and at bedtime for neuropathy, and an order dated 09/18/24 for the narcotic pain medication Ultram oral capsule 50 mg by mouth every morning and at bedtime for pain. Review of the medication administration record (MAR) for October 2024 revealed on 10/11/24 the morning doses of Ultram and gabapentin were not documented as administered and were coded with a 9. In addition, on 10/19/24, the morning dose of gabapentin was not documented as administered and was coded with a 9. Review of the nursing progress notes dated 10/11/24 and timed 7:09 P.M. revealed Resident #16's Ultram and gabapentin were not administered due to timing. Review of the nursing progress notes dated 10/19/24 and timed 2:43 P.M. revealed Resident #16's gabapentin was not administered due to a time constraint. An interview on 12/04/24 at 12:24 P.M. with Resident #16 revealed the resident did not always receive medications as ordered. An interview on 12/09/24 at 12:00 P.M. with Licensed Practical Nurse (LPN) #802 verified Resident #16's Ultram was not administered as ordered on 10/11/24 and confirmed gabapentin was not administered on 10/11/24 and 10/19/24 as ordered. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Administering Medications, revised December 2012, revealed medications shall be administered in a safe and timely manner, and as prescribed. In addition, the policy stated medications must be administered in accordance with the orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number OH00159718.		