

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

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

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 02/27/2025
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** 44454 Based on medical record review, observation, resident interview, and staff interview, the facility failed to provide a clean and homelike environment. This affected one resident (#11) of six residents reviewed for environment. The facility census was 89. Findings include: Review of the medical record revealed Resident #11 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, heart failure, depression, panic disorder, insomnia, history of falling, restless leg syndrome, and migraine. Review of the Minimum Data Set annual assessment dated [DATE], revealed Resident #11 was cognitively intact. The resident required supervision or touching assistance for transfers and for walking ten feet once standing. Review of Resident #11's medical record revealed no documented information regarding the resident's bed linens. Interview on 02/24/25 at 3:41 P.M. with Resident #11 revealed staff never washed the resident's sheets. Resident #11 reported it had probably been approximately one month since the last time her sheets were changed. Resident #11 reported the top-left corner of the fitted sheet on her bed had been coming off of the corner for awhile and she was unable to put it back on her own. Resident #11 reported having her own sheets due to having a unique bed and that there were extra sheets staff could use. Observation on 02/24/25 at 3:41 P.M. revealed Resident #11's bed had a light purple fitted sheet which was completely off of the top left corner of the bed. There were numerous brownish-red smears covering the side of the sheet which was facing the doorway. There was also a pillowcase hanging off of the siderail attached to the resident's bed, which had numerous brownish-red smears all over it. The resident reported the smears were all dried blood stains due to her picking at her skin. Observations on 02/25/25 at 3:25 P.M. and on 02/26/25 at 9:25 A.M. revealed Resident #11 was resting in bed. The resident's sheets were in the same condition, including the top-left corner coming off of the mattress and the smears located on the fitted sheet and pillowcase. The condition of the sheets was visible from the hallway. (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	Interview on 02/26/25 at 9:34 A.M. with Certified Nursing Assistant (CNA) #940 revealed there was no set schedule for resident bed linens to be changed. CNA #940 verified bed linens should be changed whenever they were visibly dirty or soiled. CNA #940 was unsure of whether Resident #11 had their own sheets. Observation on 02/26/25 at 9:41 A.M. with CNA #940 verified the condition of Resident #11's sheets. CNA #940 asked Resident #11 if CNA #940 could change Resident #11's sheets and the resident responded yes, they have been dirty for awhile.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, observation, resident interview, staff interview, and review of facility policy, the facility failed to assist residents in obtaining routine dental care. This affected one resident (#68) of two residents reviewed for dental care. The facility census was 89. Findings include: Review of the medical record revealed Resident #68 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, depression, anxiety, hypertension, and peripheral vascular disease. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #68 was cognitively intact. The resident did not have any broken teeth or dentures. Review of the current physician orders for February 2025 identified an order dated 06/12/23 for may consult dental as needed. Review of Resident #68's medical record revealed no evidence the resident was ever offered or received routine dental services while residing in the facility. Interview on 02/24/25 at 9:39 A.M. revealed Resident #11 stated they needed dentures because their teeth were rotting. Resident #11 reported no one at the facility had inquired about dental services and the resident had not seen a dentist since residing in the facility. Observation on 02/24/25 at 9:39 A.M. revealed Resident #11 had visibly darkened areas on several of their teeth. Interview on 02/26/25 at 11:30 A.M. with the Regional Director of Clinical Services #721 revealed there was a dentist who came into the facility on a quarterly basis. The Regional Director of Clinical Services #721 reported residents were screened for whether they would like dental services upon admission to the facility. A follow-up interview on 02/27/25 at 11:30 A.M. with the Regional Director of Clinical Services #721 revealed the facility could not find Resident #68's admission documents to confirm whether or not the resident was offered dental services. The Regional Director of Clinical Services #721 verified there was no evidence Resident #68 was ever offered or received routine dental services while residing in the facility. Review of the facility policy titled Dental Services, revised December 2016, revealed routine and emergency dental services were available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. The policy also stated all dental services provided would be recorded in the resident's medical record.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on record review, observation, resident interview, and staff interview, the facility failed to ensure Resident #68 timely received an evaluation by therapy services for a motorized wheelchair. This affected one (Resident #68) of five residents reviewed for rehabilitation services. The facility census was 89. Findings include: Review of the medical record revealed Resident #68 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, depression, anxiety, hypertension, and peripheral vascular disease. Review of the Minimum Data Set quarterly assessment dated [DATE] revealed Resident #68 was cognitively intact. The resident was dependent on assistance from staff for activities of daily living. Review of Resident #68's general progress notes dated 08/07/24 and timed 5:51 P.M. revealed a nurse practitioner was in to see the resident. The resident requested to get a motorized wheelchair with a new order for a therapy consultation for a motorized wheelchair evaluation. Review of Resident #68's general progress notes dated 12/09/24 and timed 3:03 P.M. revealed a nurse practitioner was in the facility making rounds with a new order for a therapy evaluation for a motorized wheelchair. Review of the current physician orders for February 2025 identified an order dated 12/09/24 for consultation with therapy for a motorized wheelchair evaluation. Review of Resident #68's medical record revealed no evidence the resident was ever evaluated by therapy for a motorized wheelchair. Interview on 02/24/25 at 9:30 A.M. revealed Resident #11 stated they had requested a motorized wheelchair multiple times but had never been evaluated for or received one. Observation on 02/24/25 at 9:30 A.M. revealed there was no wheelchair in Resident #11's room. Interview on 02/26/25 at 8:34 A.M. with the Director of Therapy Services #742 verified Resident #11 had an order dated 12/09/24 for therapy to evaluate the resident for a motorized wheelchair and the resident had never been evaluated for one. Interview on 02/27/25 at 11:30 A.M. with the Regional Director of Clinical Services #721 verified Resident #68 had expressed interest in a motorized wheelchair on 08/07/24 and on 12/09/24 with a new order to be evaluated by therapy. The Regional Director of Clinical Services #721 verified there was no evidence or documentation the resident had ever been evaluated by therapy for a motorized wheelchair.		