

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X(2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X(3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/23/11</p> <p>Facility Number: 000557 Provider Number: 155455 AIM Number: 100291240</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Wesleyan Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire</p>	K0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms with the exception of the resident rooms located on Harbor Lane, Memory Lane and Willow Court. The facility has a capacity of 169 and had a census of 130 at the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/28/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0025 SS=D	<p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect all residents in or near the Dietary office in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator in Training and the Maintenance Supervisor on 03/23/11 at 12:56 p.m., there was a one half inch gap between the attic access stairs and the ceiling in the Dietary office. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K0025	<p>K 025 Corrective Actions Taken for those residents affected by the alleged deficient practice:</p> <p>This deficient practice could affect all the residents in or near dietary office in the event of an emergency. The deficient was corrected by replacing the barrier with one hour fire resistance rating barrier and the gap has been sealed.</p> <p>Identification of and corrective action taken for other residents having to potential to be affected by the alleged deficient practice: The deficient practice could affect all the residents in or near dietary office in the event of an emergency. The deficient was corrected by replacing the barrier with appropriate rating and sealing the gap.</p> <p>Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: Maintenance Director/Designee will inspect throughout the facility for such deficient and correct upon findings. Any findings would be reported to the administrator and will be corrected by 4/22/2011.</p> <p>How the corrective actions will be monitored and the QA system implemented to ensure</p>	04/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			the alleged deficient practice does notrecur: The reports of findings willbe reviewed in QA quarterly meeting by Administrator for compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0050 SS=F	<p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Monthly Fire Drill Evacuation Alarm/Drill Report" with the Administrator in Training and the Maintenance Supervisor on 03/23/11 at 10:28 a.m., there was no record of a second shift fire drill for the second quarter of 2010. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p>	K0050	<p><u>K 050</u> Corrective Actions Taken for those residents affected by the alleged deficient practice: All residents and staff were affected by the alleged deficient practice. The maintenance director was educated by the Corporate Director of Maintenance on the frequency of drills to be conducted and requirement to log the time and date of drills conducted. The drills will include each shift on a quarterly basis with minimum of (4) four hours variance within a shift. Drills are held on a monthly basis.</p> <p>Identification of and corrective action taken for other residents having potential to be affected by the alleged deficient practice: All residents and staff have the potential to be affected by the alleged deficient practice. The Administrator will monitor the compliance of the drill protocol and monitor the drill log monthly. The fire drills will be entered into TELS program for electronic filing by Maint. Director/Designee.</p> <p>Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: The Maint Director/Designee will insure that the drills will be conducted on all shifts to meet the state</p>	04/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>guidelines and maintain the logs with time and datedrills were conducted. The logs will be reviewed by the Administrator monthlyfor compliance.</p> <p>How the corrective actions will bemonitored and the QA system implemented to ensure the alleged deficientpractice does not recur: Thedrill logs will be reviewed during Quarterly QA meeting by theAdministrator/Designee for compliance until 100% compliance is met on-going.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0056 SS=F	<p>Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers was installed in four rooms in 2 of 10 smoke compartments. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect all residents in the main dining room and any number of staff in the Therapy/business exit passageway.</p> <p>Findings include:</p> <p>Based on observations with the Administrator in Training and the Maintenance Supervisor on 03/23/11 between 11:30 a.m. and 12:00 p.m., the Therapy/business exit passageway and the main dining room had what appear to be a mixture of sprinkler heads with the glass rods and standard response sprinkler heads. Based</p>	K0056	<p><u>K 056</u></p> <p>- Corrective Actions Taken for those residents affected by the alleged deficient practice: All residents and staff have the potential to be affected by the alleged deficient practice. The Maintenance Director conducted visual inspection of the entire facility. Three areas were found to be affected by the alleged deficient practice. The sprinkler head in the Therapy/Business Exit passageway was replaced to match the rating with remaining sprinkler heads.</p> <p>Identification of and corrective action taken for other residents having potential to be affected by the alleged deficient practice: All residents and staff have the potential to be affected by the alleged deficient practice. The sprinkler head was replaced to match the rating of remainder heads. The sprinkler company (VFP) has been contracted to inspect and replace the sprinkler heads matching the rating throughout the facility.</p> <p>Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: The sprinkler will be inspected by VFP system throughout the facility to insure that rating all heads have</p>	04/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>on an interview with the Maintenance Supervisor at the time of observations, he could confirm the standard response sprinkler head were rated at 165 degrees Farenheit but he could not find a rating of the remaining sprinkler heads therefore he could not confirm the rating of these sprinkler heads.</p> <p>3.1-19(b)</p>		<p>matching rating. The VFP system will provide service report to the Administrator to insure 100% compliance is met.</p> <p>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: The administrator will audit the service report from VFP to insure that sprinkler heads are replaced and matching after the completion of work during QA quarterly meeting</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0130 SS=E	Based on observation and interview, the facility failed to ensure 7 of 7 penetrations of both fire barrier walls in Fire Side Court were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item	K0130	K 130 Corrective Actions Taken for those residents affected by the alleged deficient practice: All residents, Staff and Guests have the potential to be affected by the alleged deficient practice. The Maintenance Director/Designee purchased the appropriate fire caulk putty and sealed the penetration areas identified immediately. The Maintenance Director/Designee inspected the entire Attic areas throughout the building and concern corrected. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: The Maint. Director/Designee has inspected the attic space throughout the building and areas of concern corrected. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: The inspection of attic area throughout the facility was conducted by the Maintenance Director. The maintenance director/ Designee will include inspection of attic space area on facility monthly checklist report on-going. How the corrective actions will	04/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect thirty three residents in Fire Side Court, twenty three residents in Memory Lane, and the assisted living residents.</p> <p>Findings include:</p> <p>Based on observations with the Administrator in Training and the Maintenance Supervisor on 03/23/11 from 12:40 p.m. and 12:45 p.m., the following penetrations were in both attic fire barrier walls of Fire Side Court:</p> <p>a) between Fire Side Court and Memory Lane there were three unsealed penetrations containing cable wires and two empty unsealed penetrations each of the</p>		<p>bemonitored and the QA system implemented to ensure the alleged deficientpractice does not recur: The resultsof reports will be reviewed during QA quarterly by Administrator forcompliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>five penetrations measured one inch</p> <p>b) between Fire Side Court and the assisted living hall there were two unsealed penetrations containing cable wires measuring one half inch.</p> <p>Based on an interview with the Maintenance Supervisor at the time of the observations, the walls were fire barrier walls.</p> <p>3.1-19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0144 SS=E	<p>Based on observation and interview, the facility failed to maintain emergency task lighting in and around 1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator in Training and the Maintenance Supervisor on 03/23/11 at 11:25 a.m., a battery operated emergency task light was provided at the emergency generator but failed to illuminate when tested. This was acknowledged by the Maintenance Supervisor at the time of</p>	K0144	<p><u>K 144</u></p> <p>- Corrective Actions Taken for those residents affected by the alleged deficient practice: All residents and staff have the potential to be affected by the alleged deficient practice. The maintenance director has replaced the battery backup lighting and it is functional. The Maint. Director/Designee will inspect the battery backup during the generator test.</p> <p>Identification of and corrective action taken for other residents having potential to be affected by the alleged deficient practice: All residents and staff have the potential to be affected by the alleged deficient practice. All battery back-up lights throughout the facility will be inspected for proper functionality by Maint. Director/Designee. An audit tool will be created to ensure that the findings are monitored.</p> <p>Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: The battery backup light was replaced and it is functioning.</p> <p>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice</p>	04/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 WEST 35TH ST MARION, IN46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	observation. 3.1-19(b)		does not recur: The resultsof audit will be reviewed in QA quarterly until 100% compliance is meton-going.		