

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953
---	--

(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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: July 9, 10, 11, 12, 15 and 16, 2013</p> <p>Facility number: 000557 Provider number: 155455 AIM number: 100291240</p> <p>Survey team: Toni Maley, BSW- TC Linn Mackey, RN (7/9/13, 7/10/13, 7/11/13, 7/12/13) Karen K Koeberlein, RN Shelly Reed, RN (7/9/13, 7/10/13)</p> <p>Census bed type: SNF/NF: 118 SNF: 6 Residential: 7 Total: 131</p> <p>Census payor type: Medicare: 6 Medicaid: 96 Other: 29 Total: 131</p> <p>Residential Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F000000	<p>F 0000This Plan of Correction is preparedand executed because it is requiredby the provisions of State and Federallaws and regulations and not becauseWesleyan Health Care Center agreeswith the allegations and citations listed.Wesleyan Health Care Center maintainsthat the alleged deficiencies do notindividually or collectively jeopardizethe health and safety of the residents,nor are they of such a character so as tolimit our capabilities to render adequatecare.</p>	
---------	---	---------	---	--

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 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/16/2013
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953		
(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	
	IAC 16.2.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/16/2013	
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953			
(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			
F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure employees spoke to residents in a respectful volume for 1 of 1 resident reviewed for dignity. (Resident #122)</p> <p>Findings include:</p> <p>During a 7/10/13, 9:05 a.m., observation of the breakfast meal, while standing approximately 40 feet from the Crystal dining room, two loud voices could be heard. The words "shut up" and "social services" could be heard. Upon entering the Crystal dining room. Resident #122 and CNA #1 were facing each other. Resident #122 yelled "shut up" repeatedly. In a very loud voice, CNA #1 indicated the problem could be taken to the social services department. At this time Unit Manager #2 entered the area and spoke to Resident #122 in a calm voice and escorted her from the area. Resident #122 was calm when speaking to UM #2.</p>	F000241	<p>F241</p> <p>Corrected actions taken for those residents affected by the alleged deficient practice:</p> <p>Resident #122 was provided with counseling related to the occurrence by Social Services and assured that resident's dignity would be maintained by facility.</p> <p>Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice:</p> <p>All residents have the potential to be affected by the alleged deficient practice. All facility staff in serviced to provide education on maintaining resident dignity. To be completed on or before 8/5/2013.</p> <p>Measures taken and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>All facility staff in service conducted to educate staff on maintaining resident dignity. DON/ Designee to conduct daily rounds in dining areas to ensure resident dignity is maintained for thirty days, then three times per week for thirty days, and then weekly ongoing.</p> <p>How the corrective actions will be monitored and the QA system</p>	08/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/16/2013	
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953			
(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>During a 7/11/13, 2:53 p.m., interview, Resident #122 indicated CNA #1 had raised her voice when speaking with her on the morning of 7/10/13. Resident #122 indicated she herself had yelled and got very loud. She indicated she thought CNA #1 had gotten very loud to be heard over Resident #122's yelling. The resident indicated she was not afraid or worried about CNA #1's volume. Resident #122 indicated she was yelling at the CNA so loudly CNA #1 had to yell back.</p> <p>Resident #122's record was reviewed on 7/11/13 at 4:26 p.m.</p> <p>Resident #122's current diagnoses included, but were not limited to, depression, hypertension and diabetes mellitus.</p> <p>Resident #122 had a current, 5/17/13, significant change, Minimum Data Set (MDS) assessment which indicated she did not have cognitive limitation.</p> <p>During a 7/10/13, 9:15 a.m., interview, the Director of Nursing indicated Resident #122 had been upset about table placement. The Social Service Director was the person with whom Resident #122 was to share complaints and concerns.</p>		<p>implemented to ensure the alleged deficient practice does not recur: A quality assurance audit will be completed by DON/Designee and results of audits will be discussed at monthly QA committee meetings and any concerns will be addressed. This QA audit will be ongoing. Completion Date: August 5, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953
---	--

(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>CNA #1 should have directed Resident #122 to the Social Services Director. The Director of Nursing indicated she would investigate CNA #1's volume when speaking to Resident #122.</p> <p>A 7/10/13, written statement by CNA #1 indicated the dining area was loud with kitchen and dining room noises when Resident #122 yelled. The statement indicated "...my voice may have been raised but was not meaning to yell but the back ground noise did not help."</p> <p>A 7/10/13 "Incident Report Form" indicated staff and residents were interviewed regarding the verbal exchange between Resident #122 and CNA #1. The investigation determined all who were present did not feel CNA #1 was yelling at or threatening Resident #122 and may have been loud to be heard over background noises and the residents volume. CNA #1 was counseled regarding communication with angry residents and maintaining a professional volume when communicating.</p> <p>3.1-3(m) 3.1-3(t)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953
---	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/16/2013	
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953			
(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			
F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review, the facility failed to ensure clinical records were complete and accurately documented regarding skin conditions for 1 of 3 residents who met the criteria for skin conditions. (Resident #87)</p> <p>Findings include:</p> <p>During an observation on 7/9/13 at 11:30 a.m., Resident #87 was observed with a bruise on the back of the left hand which measured 2 inches by 2 inches. During an interview at this time, Resident #87 was asked about the bruise, and replied "It's from my medicine."</p> <p>Record Review on 7/11/13 at 8:42 a.m. of Resident #87's medication</p>	F000514	<p>F 514 Corrective actions taken for those residents affected by the alleged deficient practice: Skin assessment completed on resident #87 and updated as needed for accuracy. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. Nursing in service conducted with all nursing staff to provide education on policy and procedure related to skin concerns and assessments completed on all residents and updated as needed for accuracy on or before 8/5/2013. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur:</p>	08/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/16/2013
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953		
(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>orders, did not include aspirin or any form of blood thinners.</p> <p>Review of Resident #87's care plan included the most recent skin assessment dated 7/9/13 at 4:50 p.m. On the question,"does the resident have any bruising," it was answered "no." (This was the same date of the original bruise observation at 11:30 a.m.).</p> <p>During an interview on 7/12/13 at 12:05 p.m.,CNA #3 was asked what she would do if she noted a new bruise on a resident. CNA #3 answered, "I tell the nurse and she looks at the bruise and assesses it and starts an investigation."</p> <p>During an interview with Nurse #4 on 7/12/13 at 12:30 p.m.,the nurse was asked what she should do when a CNA reported a new bruise on a resident to her. Nurse #4 answered," I assess the bruises and measure them, I update the skin assessment sheet, and start an investigation of the reason for the bruises."</p> <p>A Nurse Practitioner progress note provided on 7/15/13 at 3:30 p.m., indicated the resident had a skin assessment on this same date and was found to have a skin</p>		<p>Skin assessments completed on all residents and updated for accuracy. DON/Designee to audit skin assessments of three residents per hall three times per week for three months, then weekly ongoing. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: A quality assurance audit will be completed by the DON/Designee and results will be discussed at monthly QA committee meeting and any concerns will be addressed. This QA audit will be ongoing. Completion Date 8/5/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/16/2013
NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953		
(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>discoloration known as senile purapura (elder bruising not necessarily caused by trauma).</p> <p>3.1- 50 (a) (1) 3.1- 50 (a) (2)</p>				