

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155455</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/15/2024</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WESLEYAN HEALTH CARE CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>729 WEST 35TH ST MARION, IN 46953</b>			
(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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code Preoccupancy Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.</p> <p>Facility Renovation: Remodeling at the facility to accommodate the creation of a six-bay dialysis unit for the use of residents only. Remodeling includes the removal of two resident rooms, formerly numbered 65 and 67, and an existing Soiled room from the licensed floorplan, the creation of a single corridor-facing restroom, and general renovations to connecting spaces. Remodeling of two corridor-access restrooms adjacent to existing resident room 63 into a new Soiled room. Renovations to resident room 90 to allow for two (2) residents. Relocation of one T18/19 bed each from rooms 10, 12, 13, 14, 15, 16, and 17 to rooms 80, 82, 84, and 90.</p> <p>Survey Date: 05/15/24</p> <p>Facility Number: 000557 Provider Number: 155455 AIM Number: 100291240</p> <p>At this Preoccupancy survey, Wesleyan Health Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 alarm system</p>			K 000			
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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155455</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/15/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESLEYAN HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>729 WEST 35TH ST</b> <b>MARION, IN 46953</b>		
(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	
K 000	<p>Continued From page 1</p> <p>with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 169 and had a census of 97 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>It was determined that the separation wall between the Nursing Facility and the Assisted Living Hall had a one hour fire rating which required it to be surveyed also.</p> <p>Quality Review completed on 05/16/24</p>	K 000			