CENTERS FOR MEDICARE & MEDICAID SERVICES						ON	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155658		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/20/2023		
	PROVIDER OR SUPPLIEI			1555 N	ADDRESS, CITY, STATE, ZIP COD I MAIN ST KFORT, IN 46041	•	
(X4) ID PREFIX TAG E 0000 Bldg	SUMMARY (EACH DEFICIEN REGULATORY OF An Emergency Preconducted by the Ir accordance with 42 Survey Date: 04/20 Facility Number: 04 Provider Number: AIM Number: 200 At this Emergency Manor Health Cent with Emergency Pr Medicare and Mediand Suppliers, 42 C The facility has 96 the survey, the cens	statement of deficiencie acy Must be preceded by full related	E 00	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPEDEFICIENCY) Wesley Manor considers itself partner with regulatory agent and others who monitor the conference of care and services, and we welcome feedback received these entities to continually improve the care and services we provide. We submit this F Correction in recognition of the importance of receiving this feedback to continually refine practices. This Plan of Correction consists the written allegation of compliance for the deficience cited. However, submission that a deficiency or that one was cited correct. This Plan of Correction is submitted to meet requirement established by state and fedilaw. Wesley Manor desires this F Correction to be considered.	elf a cies quality e by es that Plan of the e our stitutes ies of this exists tly. ents eral	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code	Recertification and State	K 0	000	Allegation of Compliance. Compliance is effective on M 17, 2023. Wesley Manor considers itse	·	
	Licensure survey w	vas conducted by the Indiana Ith in accordance with 42 CFR	KU	UUU	partner with regulatory agen- and others who monitor the of of care and services, and we	cies quality	

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

TITLE

welcome feedback received by

(X6) DATE

Gary "BRENT" Waymire

Executive Director / Administrator

05/05/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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STREET ADDRESS, CITY, STATE, ZIP COD		TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155658	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/20/2023
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Eacility Number: 001152 Provider Number: 200221050 At this Life Safety Code survey, Wesley Manor Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This Facility was surveyed as two buildings because of different construction types. The F wing, located on the ground and first floors of a four story fully sprinklered building with a basement was determined to be Type II (000) construction. The G and H vings were one story, fully sprinklered and determined to be Type II (000) construction. The facility has a fire alarm system with smoke detector in in the corridors, spaces open to the corridors and hard-wired smoke detectors in resident rooms. The facility has a capacity of 96 and had a census of 86 at the time of this survey. All areas which provide customary access to residents were sprinklered. All areas which provide facility services such as the laundry, generator room, boiler room and the maintenance department were not sprinklered. Quality Review completed on 04/26/23			1555 N	MAIN ST	
Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050 At this Life Safety Code survey, Wesley Manor Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483,90(a), Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was surveyed as two buildings because of different construction types. The F wing, located on the ground and first floors of a four story fully sprinklered building with a basement was determined to be Type II (202) construction. The G and H wings were one story, fully sprinklered and determined to be Type II (000) construction. The facility has a lire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in resident rooms. The facility has a capacity of 96 and had a census of 86 at the time of this survey. All areas which provide customary access to residents were sprinklered. All areas which provide facility services such as the laundry, generator room, boiler room and the maintenance department were not sprinklered.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
	K 0000	Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050 At this Life Safety Code survey, Wesley Manor Health Center was found not 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. This facility was surveyed as two buildings because of different construction types. The F wing, located on the ground and first floors of a four story fully sprinklered building with a basement was determined to be Type II (222) construction. The G and H wings were one story, fully sprinklered and determined to be Type II (000) construction. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in resident rooms. The facility has a capacity of 96 and had a census of 86 at the time of this survey. All areas which provide customary access to residents were sprinklered. All areas which provide facility services such as the laundry, generator room, boiler room and the maintenance department were not sprinklered.		improve the care and services we provide. We submit this Place Correction in recognition of the importance of receiving this feedback to continually refine practices. This Plan of Correction constitute written allegation of compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly. This Plan of Correction is submitted to meet requirement established by state and feder law. Wesley Manor desires this Place Correction to be considered of Allegation of Compliance. Compliance is effective on Market in the provided state of the considered of the compliance.	an of e our tutes s this tists ts ral an of
Bldg. 02					

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED	
155658		B. W	B. WING 04/20/20			2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
MEOLEM	MANOD LIEALTH	OENTED			MAIN ST		
WESLEY	MANOR HEALTH	CENTER		FRANK	(FORT, IN 46041		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A Life Safety Code	Recertification and State	K 0	000	Wesley Manor considers itself	a	
	Licensure survey w	as conducted by the Indiana			partner with regulatory agenci	es	
	Department of Heal	th in accordance with 42 CFR			and others who monitor the qu	uality	
	483.90(a).				of care and services, and we	-	
					welcome feedback received by	y	
	Survey Date: 04/20	0/23			these entities to continually		
					improve the care and services	that	
	Facility Number: 0				we provide. We submit this Pla	an of	
	Provider Number:	155658			Correction in recognition of the	Э	
	AIM Number: 2002	221050			importance of receiving this		
					feedback to continually refine	our	
	-	Code survey, Wesley Manor			practices.		
		found not in compliance with			This Plan of Correction constit	utes	
	Requirements for Pa	-			the written allegation of		
		, 42 CFR Subpart 483.90(a),			compliance for the deficiencies	s	
	-	re, and the 2012 edition of the			cited. However, submission of	this	
		ction Association (NFPA) 101,			Plan of Correction is not an		
	•	SC), Chapter 19, Existing			admission that a deficiency ex		
	Health Care Occupa	ancies and 410 IAC 16.2.			or that one was cited correctly		
	TEL : C :1:4	1 4 1 712			This Plan of Correction is		
		rveyed as two buildings			submitted to meet requiremen		
		construction types. The F			established by state and feder	aı	
	-	e ground and first floors of a			law.		
		nklered building with a mined to be Type II (222)			Wesley Manor desires this Pla		
		and H wings were one story,			Correction to be considered or Allegation of Compliance.	มเ	
		d determined to be Type II			Compliance is effective on Ma	N/	
		The facility has a fire alarm			17, 2023.	у	
		detection in the corridors,			17, 2023.		
spaces open to the corridors and hard-wired smoke detectors in resident rooms. The facility							
		and had a census of 86 at the					
	time of this survey.						
	inite of time survey.						
	All areas which pro	vide customary access to					
	-	klered. All areas which					
	•	vices such as the laundry,					
		ler room and the maintenance					
	department were no						
	asparament were no	- sp.maiorea.					
					1	ļ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155658		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 04/20/2023	
	PROVIDER OR SUPPLIER		1555 N	ADDRESS, CITY, STATE, ZIP COD I MAIN ST (FORT, IN 46041	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION rpleted on 04/26/23	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0311 SS=E Bldg. 02	NFPA 101 Vertical Openings Vertical Openings 2012 EXISTING Stairways, elevator ventilation shafts, openings between construction having at least 1 hour. An accordance with 8 19.3.1.1 through 1 If all vertical opening with construction in fire resistance ration box. Based on observation failed to ensure the openings in accordance with openings in accordance with otherwise permitted 8.3.4.2 requires fire shafts, including staresistance rating. Less door assemblies have protection rating shafts including staresistance rating. Less door assemblies have protection rating shafts, including staresistance rating. Less door assemblies have protection rating shafts including staresistance rating. Less door assemblies have protection rating shafts including staresistance rating. Less door assemblies have protection rating shafts including staresistance rating. Less door assemblies have protection rating shafts in Table 8. could affect as many visitors within the firm of the minimum required in Table 8. could affect as many visitors within the firm of the minimum required in Table 8. could affect as many visitors within the firm of the minimum required in Table 8. could affect as many visitors within the firm of the minimum required in Table 8.	- Enclosure - Enclosure or shafts, light and chutes, and other vertical afloors are enclosed with a floors are enclosed with a fire resistance rating of a tarium may be used in 6.6. 19.3.1.6 angs are properly enclosed providing at least a 2-hour ang, also check this on and interview, the facility protection of 1 of 2 vertical ance with 19.3.1. LSC 19.3.1.1 are is provided, the avenot less than a 1-hour fire SC 8.3.4.2 states the fire are opening protectives shall be are not less than a 1-hour fire and assemblies in vertical and a semblies in vertical and a minimum 3/4-hour fire all be permitted to continue to openings and exit enclosures in a 1-hour fire protection rating 3.4.2. This deficient practice as 18 residents, 6 staff and 2	K 0311	It is the policy of Wesley Mandassure vertical openings — enclosure, such as stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings betwee floors are enclosed with construction having a fire resistance rating in accordance with the life safety code. How will corrective action be accomplished for those reside found to have been affected be the alleged deficient practice? The elevator separation door labeled as G 103 was adjusted immediately following the life safety visit on April 20, 2023, sthat it would fully close and lat See the attached photo — Attachment — K 311 — A. How will the facility identify other residents having the potential	en nts Y d so ch.

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PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155658		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 04/20/2023	
	PROVIDER OR SUPPLIE		1555 N	ADDRESS, CITY, STATE, ZIP COD N MAIN ST KFORT, IN 46041	•
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
TAG	facility with the M at 1:24 p.m., the se door labeled as G latch leaving a 1-in closed to its fullest Maintenance Direct	aintenance Director on 04/20/23 acond-floor elevator separation 103 failed to fully close and ach gap when the door was a This was verified by the stor at the time of observation would have his staff address ely.	TAG	be affected by the same allegate deficient practice? An audit was completed on A 21, 2023, of all the fire doors located in the community, to with the tall doors fully closed and latched. See the attached aud Attachment – K 311 – B. The audit found no other fire affected. What measures will be put integrated by the place or systematic changes made to ensure that the allegate deficient practice will not recurved by Manor will continue it practice of inspecting fire door monthly. Doors which are four that do not fully close, latch, or meet the provisions of the life safety code will be repaired immediately upon discovery. How will the facility monitor its corrective actions to ensure the allegated deficient practice not recur? Through routine and random rounds, the Maintenance Directive will review Fire Doors to assure that they close fully, latch and meet the applicable requirem of the life safety code. The results of the Fire Door Monthly Inspection audits for previous month will be reported the QAPI Subcommittee Mee (MEGA Meeting) for Safety wis held one time monthly for the QAPI Committee Quarter Depending on the progress, or the progress or th	pril verify dit — doors co ed ur? s rs nd or s eat will ector re l ents the ed in ting hich ne ed to ly.

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Event ID:

 $N7CM21 \quad \text{Facility ID:} \quad 001152$

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PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155658		A. BUILDING B. WING	02	COMPLETED 04/20/2023	
	ROVIDER OR SUPPLIER		1555 N	ADDRESS, CITY, STATE, ZIP COD I MAIN ST KFORT, IN 46041	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				lack thereof, the QAPI Commit will determine the reporting frequency on a go forward bas	
K 0363 SS=E Bldg. 02	than required enclexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combustible mater covering is not except to a complying with a containing the door closed what applied. There is closing of the door release when the copermitted. Nonrate unlimited height armeeting 19.3.6.3.6 frames shall be late other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restricts	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor seeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the res. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 04/20/2023 155658 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1555 N MAIN ST WESLEY MANOR HEALTH CENTER FRANKFORT, IN 46041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility K 0363 05/17/2023 It is the policy of Wesley Manor to failed to ensure 1 of over 100 corridor doors were ensure corridor doors protecting provided with a means suitable for keeping the corridor openings meet the door closed, had no impediment to closing, applicable provisions of the life latching, and would resist the passage of smoke. safety code. This deficient practice could affect 30 residents, How will corrective action be 10 staff and 2 visitors. accomplished for those residents found to have been affected by Findings include: the alleged deficient practice? The kick stop mounted to the Based on observations made during a tour of the kitchen door labeled as G 1110 facility with the Maintenance Director on 04/20/23 was removed immediately at 1:24 p.m., the second-floor kitchen door to the following the life safety visit on corridor had a kick stop mounted on the bottom of April 20, 2023, so that it could not the door. This was holding the door to the be propped open again. See the corridor, a door that had a self-closing device attached photo - Attachment - K mounted on it, in the open position. Based on 363 - A.interview at the time of observation, the How will the facility identify other Maintenance Director acknowledged the residents having the potential to aforementioned corridor door as being propped in be affected by the same alleged the fully open position with a door wedge and deficient practice? stated that he would have it removed as soon as An audit was completed on May possible. 1, 2023, of all the hazard area doors located in the community, 3.1-19(b) to verify that all doors had no kick stand type device installed on them and that they met the intent of the life safety code. See the attached audit – Attachment – K 363 - BThe audit found no other hazard area doors affected. What measures will be put into

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PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155658	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	_	SURVEY LETED 1/2023
NAME OF PROVIDER OR SUPPLIER WESLEY MANOR HEALTH CENTER		1555 N	ADDRESS, CITY, STATE, ZIP CO I MAIN ST KFORT, IN 46041	OD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
				place or systematic charmade to ensure that the deficient practice will not wesley Manor will conting practice of inspecting his doors monthly. Doors we found that do not meet provisions of the life sat will be repaired immediatiscovery. How will the facility more corrective actions to enthe alleged deficient pranot recur? Through routine and rail rounds, the Maintenance will review Hazard Area assure that they do not kick stop device and are propped open and mee applicable requirements safety code. The results of the Hazard Door Monthly Inspection the previous month will in the QAPI Subcommitt Meeting (MEGA Meeting Safety which is held one monthly for the next through reported to the QAI Committee Quarterly. Don the progress, or lack the QAPI Committee widetermine the reporting on a go forward basis.	e alleged ot recur? inue its azard area which are the fety code ately upon initor its sure that actice will actice will ndom ce Director a Doors to contain a e not ot the s of the life ard Area n audits for be reported ttee ng) for e time ee months Pl Depending a thereof, ill	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include	the transmission of a fire				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER	A. BUILDING <u>02</u> COMPLET			ETED	
155658		B. WING 04/20/2023			2023		
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			MAIN ST		
WESLEY	MANOR HEALTH	CENTED			FORT, IN 46041		
WESLET	WANOR HEALTH	CENTER		FRAINK	.FOR1, IN 40041		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	alarm signal and s	simulation of emergency fire					
	conditions. Fire dr	rills are held at expected					
	and unexpected ti	mes under varying					
	conditions, at leas	st quarterly on each shift.					
	The staff is familia	ar with procedures and is					
	aware that drills a	re part of established					
	routine. Where di	rills are conducted between					
	9:00 PM and 6:00	AM, a coded					
	announcement ma	ay be used instead of					
	audible alarms.						
	19.7.1.4 through 1	19.7.1.7					
	Based on record rev	view and interview, the facility	K 0	712	It is the policy of Wesley Mand	or to	05/17/2023
	failed to ensure 12	of 12 fire drills included the		ensure fire drills include the			
	verification of trans	smission of the fire alarm signal			transmission of a fire alarm sig	gnal	
	to the monitoring st	tation in fire drills for the last 4			and simulation of emergency f	ire	
	quarters. LSC 19.7.	1.4 requires fire drills in health			conditions, as well as other		
	care occupancies sh	nall include the transmission of			provisions of the life safety cod	de.	
	a fire alarm signal a	and simulation of emergency fire			How will corrective action be		
	conditions. This de	ficient practice affects all			accomplished for those reside	<u>nts</u>	
	residents in the faci	lity as well as staff and			found to have been affected b	<u>y</u> _	
	visitors.				the alleged deficient practice?		
					The Wesley Manor Fire Drill		
	Findings include:				Report has been revised to inc	clude	
					an area to record the verificati	on of	
		view of the document titled			the transmission of the signal	for	
	•	with the Maintenance Director			drills to the monitoring compar	ıy.	
		a.m., the documentation for the			See the attached form,		
	_	velve months lacked			Attachment – K 712 – A.		
		ransmission of the signal for			How will the facility identify oth	<u>ner</u>	
		erview at the time of record			residents having the potential	<u>to</u>	
		nance Director stated that he			be affected by the same allege	<u>ed</u>	
		ing company for confirmation			<u>deficient practice?</u>		
		received during his drills but			All residents have the potentia	l to	
		the verification of the			be affected by the alleged		
	transmission of the	fire alarm signal in his records.			deficiency.		
					What measures will be put into	<u>) </u>	
	3.1-19(b)				place or systematic changes		
	3.1-51(c)				made to ensure that the allege		
					deficient practice will not recur		
					Wesley Manor will continue to		

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

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER WESLEY MANOR HEALTH CENTER X(4) ID SUMMARY STATEMENT OF DEFICIENCIE TAG ID SUMMARY STATEMENT OF DEFICIENCIE TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CONDUCT THE APPROPRIATE DEFICIENCY MILE THE PRECEDED BY FULL TAGS REGULATORY OR LSC IDENTIFYING INFORMATION CONDUCT THE APPROPRIATE DEFICIENCY With the provisions of the life safety code. The revised Fire Drill Report now contains an area to record the verification of the transmission of the signal for drills to the monitoring company. The designated personnel conducting the drill will record the verification information from the alarm monitoring company on the revised form. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? The Fire Drill Reports for the previous month will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) for Safety which is held one time monthly for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting th	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED		
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