STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000557	A. BUILDING: _____ B. WING _____	C 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEYAN HEALTH CARE CENTER	729 WEST 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) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00433127. Complaint IN00433127 - No deficiencies related to the allegations are cited. Complaint IN00432015 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00432308 - Federal/State deficiencies related to the allegations are cited at F690. Unrelated deficiencies are cited. Survey date: May 2, 3 and 6, 2024. Facility number: 000557 Residential Census: 6 Wesleyan Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00433127. Quality review completed May 16, 2024.	R 000		