STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155658	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Manor Health Center	1555 N Main St Frankfort, IN 46041

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a foley catheter placement was documented and follow-up assessments were completed after a change in urine characteristics were observed for 1 of 3 residents reviewed for catheters. (Resident B) This deficient practice resulted in Resident B being admitted to the hospital with urethral trauma.Findings include:During an interview, on 12/11/25 at 3:04 p.m., Resident B's family indicated the physician in the emergency room had indicated Resident B's catheter was inserted at the facility incorrectly. She was told a nursing student placed the catheter; the balloon was in his urethra and damaged it.The clinical record for Resident B was completed on 12/11/25 at 10:32 a.m. The diagnoses included, but were not limited to, cerebral infarction, cognitive communication deficit, benign prostatic hyperplasia with lower urinary tract symptoms, and dysuria. A care plan, dated 10/24/25, indicated Resident B had a foley catheter with a goal to remain free from catheter-related trauma. An intervention, added 12/5/25 (after the catheter was changed on 11/24/25), indicated the resident was visualized picking up the catheter bag and holding onto it or setting it up on the table. The care plan did not indicate Resident B had a history of pulling on his catheter or any interventions staff should initiate to ensure the catheter tubing was secured to prevent pulling on the catheter. A physician's order, dated 11/24/25, indicated to change the urinary catheter. The Treatment Administration Record (TAR) indicated RN 6 had changed the indwelling catheter. The physician's orders did not include the type or the size of the urinary catheter or the amount of fluid which should have been used in the balloon to anchor the catheter. A physician's order, dated 10/30/25, indicated to measure the urinary catheter output three (3) times a day in the early morning, midday, and at bedtime. On 11/24/25 at bedtime, the amount of urine documented was 175 ml (milliliters) or cc (cubic centimeters). The color of urine documented was red. There was no documentation the physician was notified on 11/24/25 at bedtime Resident B had low urine output or discolored urine. A nursing progress note, dated 11/25/25 at 1:49 a.m., indicated Resident B had complaints of abdominal pain at 12:50 a.m. Blood was noted in his catheter bag. His abdomen was tender. The physician was called at 1:07 a.m., and an order was received to send Resident B to the emergency room for an evaluation. Resident B left the facility at 1:12 a.m. The progress notes did not include documentation of the indwelling catheter change or the time the procedure occurred on 11/24/25. There was no documentation to indicate how Resident B tolerated the procedure, if there was urine return and the color of the urine, the type and size of the catheter used, and the amount of fluid used in the balloon to anchor the catheter.A hospital document, dated 11/25/25 at 1:57 a.m., indicated Resident B's chief complaint was abdominal pain. He was brought to the emergency room by emergency medical services. His foley catheter placement was exchanged at the nursing home, on 11/24/25, and presented with hematuria (blood in the urine) and blood clots. The resident reported persistent bladder pain, tenderness on both left and right sides, and a sensation of abdominal distension. The resident's exam indicated he had abdominal tenderness and mild abdominal distension. His foley catheter was in the penis and was not draining with some blood at the penile meatus (external opening at the tip of the penis). The foley catheter placed at the nursing home, on 11/24/25, was found to be very shallow, likely in the penile meatus and not in the bladder which resulted in urinary obstruction. The foley catheter was removed and a three-way catheter was placed without difficulty. There was immediate drainage of approximately 1500 cc of urine with blood. The foley catheter was found to be malpositioned which resulted in urinary obstruction and a large blood clot. A hospital discharge document, dated 11/27/25 at 8:53 a.m., indicated Resident B had a traumatic injury of the urethra (tube which carries urine from the bladder out of the body), present on admit, and suspected to be due to a urinary catheter injury. The resident's meatus had a small tear, with active oozing and bleeding from the site and a suspected higher urethral injury from improper placement/inflation of the urinary catheter balloon. During a telephone interview, on 12/10/25 at 4:01 p.m., RN 1 (a nursing student instructor from an outside entity) indicated a student nurse under her immediate supervision inserted the indwelling foley catheter into Resident B. She indicated the student prepped the area, inserted the indwelling catheter until urine was returned, advanced the catheter slightly, then blew up the balloon with the provided syringe in the sterile package. The urine returned after the catheter was inserted was a pink tinged with sediment. Resident B voiced complaints of pain in his urethral area during the procedure until the procedure was completed. She indicated neither her nor her student went back after the catheter was inserted to check on the color of the urine. She reported the procedure to the facility's dayshift nurse who was caring for Resident B. Neither her nor her student