

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  Wesley Manor Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to ensure there was documentation the bed hold policy was provided to a resident for 1 of 3 residents reviewed for discharge. (Resident 81) The deficient practice was corrected on 5/21/25, prior to the start of the survey, and was therefore past noncompliance.</p> <p>Findings include:</p> <p>The clinical record for Resident 81 was reviewed on 5/28/25 at 2:42 p.m. The diagnoses included, but were not limited to, weakness, Crohn's disease, and dementia.</p> <p>The electronic health record indicated Resident 81 was discharged from the facility to the hospital on 4/8/25.</p> <p>There was no documentation to indicate the bed hold policy had been given to the resident or the resident's representative at the time of the discharge.</p> <p>There was no documentation to indicate the bed hold policy had been emailed or sent by postal service to the resident's representative if needed.</p> <p>During an interview, on 6/2/25 at 11:47 a.m., the Executive Director indicated in May of 2025, the facility started emailing copies of the bed hold policy to the resident's representative when a resident was discharged . If the resident's representative did not have an email, a copy would be mailed to them through the postal service.</p> <p>A current facility policy, titled discharge: Bed Hold, dated as last revised 12/12/19 and received from the Associate Executive Director on 5/29/25 at 11:42 a.m., indicated .Residents or their designated representative shall be informed of this policy in writing at admission, at the time of transfer to a hospital (unless an emergency), or at the time of therapeutic leave which extends beyond twenty-four [(24)] hours. Written notification at the time of transfer shall include the Notice of Transfer and Discharge and a copy of this policy .In the event of an emergency hospitalization, the resident and a family member or legal representative shall be notified by written notice, within 24 hours, and asked to provide the facility with their decision regarding the resident's return. The staff member making the call or explaining the policy may accept verbal determination as to whether the resident desires bed hold or having their name placed on the reservation/waiting list and shall document this in the medical record</p> <p>(continued on next page)</p>

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
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, titled Notice of Transfer or Discharge, dated as last revised on 5/21/25 and received from the Associate Executive Director on 6/2/25 at 2:58 p.m., indicated .The Notice of Transfer or Discharge and Notice of Transfer or Discharge Request for Hearing will be utilized and will be provided in the transfer paperwork, [(where applicable)], given to the resident, resident representative, and a copy maintained in the clinical record .When the Notice of Transfer or Discharge and Notice of Transfer or Discharge Request for Hearing form is provided within transfer paperwork, [(resident going to the hospital)], the resident or resident representative will be provided a copy of the notices via hand-delivery, email, or sent through the postal service .Nursing will contact the resident and/or legal representative and discuss the proposed transfer and document all such communication in the resident's clinical record</p> <p>The deficient practice was corrected by 5/21/25 after the facility implemented a systemic plan which included education, audits and updates to the facility policy and procedures.</p> <p>3.1-12(a)(6)(A)(ii)</p> <p>3.1-12(a)(6)(A)(iii)</p> <p>3.1-12(25)(A)</p> <p>3.1-12(25)(B)</p> <p>3.1-12(a)(26)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on interview and record review, the facility failed to ensure the physician's orders for peritoneal dialysis were followed for 1 of 1 resident reviewed for dialysis. (Resident 50)</p> <p>Findings include:</p> <p>The clinical record for Resident 50 was reviewed on 5/29/25 at 10:17 a.m. The diagnoses included, but were not limited to, congestive heart failure, kidney failure, kidney disease, chronic obstructive pulmonary disease, type 2 diabetes mellitus, end stage renal disease, and dependence on renal dialysis.</p> <p>A physician's order, dated 12/10/24, indicated to take the resident's vital signs before and after dialysis and to use the morning weight and the systolic blood pressure to determine the dose for dialysis.</p> <p>A physician's order, dated 12/10/24, indicated the resident needed weighed every morning and when the resident's weight was greater than 216 pounds to call the dialysis clinic for further instructions. If the systolic blood pressure was less than 110, use one green (2.5% dextrose) and one yellow (1.5% dextrose) bag regardless of the weight. If the systolic blood pressure was less than 110, to use two yellow bags regardless of the weight two times a day for peritoneal dialysis.</p> <p>The physician's order which indicated the use of the different bags of solutions based on the same low systolic blood pressure result was not clarified by the facility.</p> <p>The dialysis treatment logs indicated the following:</p> <p>a. On 2/1/25, the systolic blood pressure was 100 and two green bags were given. The bags given were based on the resident's morning weight and the order for the low systolic blood pressure was not followed.</p> <p>b. On 2/6/25, the systolic blood pressure was 102 and the bag concentration used was not recorded. The bags given were based on the resident's morning weight and the order for the low systolic blood pressure was not followed.</p> <p>c. On 3/2/25, the systolic blood pressure was 107 and two green bags were given. The bags given were based on the resident's morning weight and the order for the low systolic blood pressure was not followed.</p> <p>d. On 3/3/25, the systolic blood pressure was 107 and the bag concentration used was not recorded. The bags given were based on the resident's morning weight and the order for the low systolic blood pressure was not followed.</p> <p>e. On 3/7/25, the systolic blood pressure was 88 and 1 green bag, and 1 red bag (4.25% dextrose) were given. The bags given were based on the resident's morning weight and the order for the low systolic blood pressure was not followed.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>f. On 3/28/25, the resident's weight was 219.4 pounds. There was no indication the nurse called the dialysis clinic for a treatment order. The blood pressure documented was greater than the 110 in the physician's order.</p> <p>g. On 4/13/25, the resident's weight was 218 pounds. There was no indication the nurse called the dialysis clinic for a treatment order. The blood pressure documented was greater than the 110 in the physician's order.</p> <p>h. On 4/15/25, the systolic blood pressure was 108 and one green bag, and one red bag was given. The bags given were based on the resident's morning weight and the order for the low systolic blood pressure was not followed.</p> <p>i. On 4/22/25, the systolic blood pressure was 105 and two green bags were given. The bags given were based on the resident's morning weight and the order for the low systolic blood pressure was not followed.</p> <p>j. On 5/7/25, the systolic blood pressure was 103 and one green bag, and one red bag were given. The bags given were based on the resident's morning weight and the order for the low systolic blood pressure was not followed.</p> <p>k. On 5/25/25, the systolic blood pressure was 108 and two green bags were given. The bags given were based on the resident's morning weight and the order for the low systolic blood pressure was not followed.</p> <p>A current care plan, dated 5/20/24, indicated the resident needed peritoneal dialysis related to renal failure with an approach to administer dialysis solution as ordered.</p> <p>During an interview, on 5/29/25 at 2:35 p.m., the physician indicated she would follow up with the dialysis provider to clarify the dialysis order for low systolic blood pressure. The resident had frequent lab work completed, and the orders had changed related to the labs. The current order was confusing, and the nurse would not know what concentration of bag to use.</p> <p>During an interview, on 6/2/25 at 2:21 p.m., the Director of Nursing (DON) indicated she could not find any documentation of the nurses calling the dialysis clinic for weights greater than 216 pounds on the discussed dates and they should have called to obtain guidance on the concentrations to use.</p> <p>During an interview, on 6/2/25 at 3:09 p.m., RN 2 indicated she would use the morning weight and the systolic blood pressure to determine which concentration of bags to use for the evening dialysis. The order was based on the weight unless the systolic blood pressure was less than 110 and then she would give 2 yellow bags no matter what the weight was. If his weight was greater than 216 pounds, then she would call the dialysis clinic for an order on which bags to use.</p> <p>A current facility policy, dated 11/13/22 and received from the Associate Executive Director on 6/2/25 at 2:58 p.m., indicated .The facility will maintain communication with the dialysis center per provider order and as needed</p> <p>3.1-37(a)</p>		