STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155539	A. BUILDING 00 B. WING	06/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERTHA D GARTEN KETCHAM MEMORIAL CENTER	601 E RACE ST ODON, IN 47562

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 12, 13, 14, 15, 2017 Facility number: 000300 Provider number: 155539 AIM number: 100287340 Census bed type: SNF/NF: 53 SNF: 6 Total: 59 Census payor type: Medicare: 8 Medicaid: 39 Other: 12 Total: 59 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 20, 2017.	F 0000		
F 0225	483.12(a)(3)(4)(c)(1)-(4)			

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

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SS=D Bldg. 00	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily			

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	injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to immediately notify the Administrator of an allegation of abuse for 1 of 3 allegations of abuse reviewed. (Resident 71) Findings include: On 6/14/17 at 2:02 P.M., the facility reportable's were reviewed. An incident dated 12/10/16 indicated an unnamed CNA had reported CNA 1 had been verbally abusive to Resident 71. The facility incident report indicated the	F 0225	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of	06/23/2017

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	investigation revealed the incident was reported timely to the nurse on duty, but the nurse did not immediately report the incident to the Administrator. On 6/14/17 at 2:11 P.M., the Administrator indicated the nurse on duty had notified CNA 1's supervisor of the allegation of abuse instead of notifying the Administrator of the allegation of abuse. On 6/14/17 at 2:36 P.M., the Administrator indicated the incident happened on Friday and it had not been reported to her until Monday. On 6/14/17 at 2:30 P.M., the Administrator provided the "Abuse Policy and Procedure", revised 11/28/16. The policy included, but was not limited to: Should an allegation of abuse be suspected, it should be reported immediately to the [Name of Facility] Administrator. 3.1-28(c)		compliance effective June 23, 2017 to the state findings of the State Licensure and Recertification survey conducted on June 15, 2017. F - 225 *The corrective action taken for those residents found to be affected by the deficient practice is that* the resident identified as resident #71 has not had any negative physical or psychosocial effects from the alleged event. The CNA identified as CNA #1 no longer works at the facility. In addition the nurse that the CNA reported the allegation to also no longer works at the facility. *The corrective action taken for the other residents having the potential to be affected by the same*	

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			deficient practice is that a housewide audit has been conducted to determine if there were any other allegations of abuse that had not been immediately reported to the administrator. There have been no other allegations of abuse that have not been immediately reported to the administrator identified. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for all staff on the facililty's abuse policy with an emphasis on immediately reporting all allegations of abuse to the administrator regardless of the time of day or night. Staff was instructed that failure to follow the facility policy on abuse will results	

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			in a disciplinary action which may include termination of employment. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that* a Quality Assurance tool has been developed and implemented to audit the timely and accurate reporting of all allegations of abuse. The tool will monitor the timelines to ensure that the staff are reporting all allegations of abuse to the administrator immediately upon receiving knowledge of the allegation. This tool will be completed by the Social Service Director and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. Any identified failures in	

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			following the facility's abuse policy will immediately be brought to the administrator's attention for appropriate disciplinary action. .	
F 0226 SS=D Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident			

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	abuse prevention. Based on interview and record review, the facility failed to implement their Abuse Policy and Procedure for 1 of 3 allegations of abuse reviewed. An allegation of abuse was not immediately reported to the Administrator. (Resident 71) Findings include: On 6/14/17 at 2:02 P.M., the facility reportable's were reviewed. An incident dated 12/10/16 indicated an unnamed CNA had reported CNA 1 had been verbally abusive to Resident 71. The facility incident report indicated the investigation revealed the incident was reported timely to the nurse on duty, but the nurse did not immediately report the incident to the Administrator. On 6/14/17 at 2:36 P.M., the Administrator indicated the incident happened on Friday and it had not been reported to her until Monday. On 6/14/17 at 2:30 P.M., the Administrator provided the "Abuse Policy and Procedure", revised 11/28/16. The policy included, but was not limited to: Should an allegation of abuse be suspected, it should be reported immediately to the [Name of Facility]	F 0226	F – 226 *The corrective action taken for those residents found to be affected by the deficient practice is that* the resident identified as resident #71 has not had any negative physical or psychosocial effects from the alleged event. The CNA identified as CNA #1 no longer works at the facility. In addition the nurse that the CNA reported the allegation to also no longer works at the facility. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit has been conducted to determine if there were any other allegations of abuse that	06/23/2017

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	Administrator. 3.1-28(a)		had not been immediately reported to the administrator. There have been no other allegations of abuse that have not been immediately reported to the administrator identified. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for all staff on the facililty's abuse policy with an emphasis on immediately reporting all allegations of abuse to the administrator regardless of the time of day or night. Staff was instructed that failure to follow the facility policy on abuse will results in a disciplinary action which may include termination of employment.	

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			The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to audit the timely and accurate reporting of all allegations of abuse. The tool will monitor the timelines to ensure that the staff are reporting all allegations of abuse to the administrator immediately upon receiving knowledge of the allegation. This tool will be completed by the Social Service Director and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. Any identified failures in following the facility's abuse	

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			policy will immediately be brought to the administrator's attention for appropriate disciplinary action.	
F 0441 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of			

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	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on interview and record review, the facility failed to develop a system of	F 0441		06/23/2017

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	infection control surveillance for 2 of 6 months reviewed. Findings include: On 6/13/17 at 2:00 p.m. the DON (Director of Nurses) provided the Census and Condition record. The record identified seven (7) residents as receiving antibiotics at the time of the survey. On 6/15/17 at 11:00 A.M., the ADON (Assistant Director of Nursing) provided the Infection Audit Log. The last completed month was observed to be April 2017. The ADON indicated she had not transferred the infection control information to the log since April 2017. On 6/15/17 at 11:09 A.M., RN 1 indicated she completed infection surveillance informally. She indicated the information was discussed daily in morning meeting. She indicated the information was on the daily census sheets, but she had discarded her copies once the tasks were complete. On 6/15/17 at 12:30 P.M., RN 1 indicated the staff discussed infection control issues but, it had not been documented. On 6/15/17 at 12:57 P.M., the ADON		F – 441 *The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified during the survey however all residents have the potential to be affected by the deficient practice. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents who received antibiotics from May to current have been logged on the facility infection control surveillance log and have been reviewed by the interdisciplinary team to monitor for any patterns or trends. *The measures or systematic changes that have been put into place to*	

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	indicated in order to complete the Infection Audit Log, she ran a report of residents medication orders, reviewed the orders, and transferred the information to the Infection Audit Log. On 6/15/17 at 1:11 P.M., RN 1 provided the "Surveillance for Healthcare-Associated Infections" policy revised 6/2010. The policy included, but was not limited to: The Infection Control Coordinator or designated infection control personnel is responsible for gathering and interpreting surveillance data... 3.1-18(b)(1)		*ensure that the deficient practice does not recur is that* the facility has reviewed its policy on infection control surveillance and has adopted the practice that the monthly surveillance infection control log will now be submitted to the Director of Nursing at the first of each month for the Director to review and sign off to validate the accuracy of the report. The Assistant Director of Nursing has received a one on one in-service on her responsibility for the accurate and timely completion of the infection control surveillance logs as well as the required submission of the logs monthly to the Director of Nursing. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* the monthly infection control	

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			surveillance logs will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	