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	08/29/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00440331. Complaint IN00440331: Federal/State deficiencies related to the allegations are cited at F744. Survey date: August 29, 2024 Facility number: 000300 Provider number: 155539 AIM number: 100287340 Census Bed Type: SNF: 4 SNF/NF: 55 Total: 59 Census Payor Type: Medicare: 4 Medicaid: 32 Other: 23 Total: 59 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 4, 2024.	F 0000		
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview, and record review, the facility failed to ensure resident assessments were completed and updates to the plan of care were made following wandering and exit seeking behaviors for 2 of 3 residents reviewed for dementia care and elopement. No	F 0744	By submitting the enclosed materials, 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	09/16/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Millikan	Administrator	09/16/2024

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	post elopement risk assessment was completed after a resident residing on a locked dementia unit pushed an exit door open to exit the facility and two residents with documented exit-seeking and/or wandering behaviors had no plan of care with interventions to address the behavior. (Resident B, Resident C) Findings include: 1. On 8/29/24 at 11:05 A.M., LPN 3 indicated that Resident B was at risk for elopement and that staff kept an elopement binder with Resident B's photograph and information. On 8/29/24 at 11:10 A.M., Resident B was observed ambulating in a wheelchair in a common area of a locked dementia unit and talking with staff. On 8/29/24 at 11:20 A.M., Resident B's diagnoses included, but was not limited to, severe dementia with other behavioral disturbances, muscle weakness, dependence on wheelchair, and nicotine dependence (in remission). Resident B's most recent Quarterly Minimum Data Set (MDS) assessment, dated 6/20/24, indicated the resident had severe cognitive impairment and did not display behaviors including wandering. Resident B's care plan included, but was not limited to, resident has severely impaired cognitive function/impaired thought processes due to diagnosis of dementia. The most recently added interventions included but were not limited to, provide resident cueing, reorientation, and/or supervision as needed (initiated 7/10/24). No wandering or exit seeking behaviors were included in the resident's care plan.		any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective September 16, 2024, to the state findings of the Complaint Survey conducted on August 29, 2024. F - 744 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B has now had a new elopement risk assessment completed which does reflect that the resident is at risk for elopement. In addition, the resident's care plan has been updated to address the resident's current risks for elopement including appropriate interventions. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C has now had a new elopement risk assessment completed which does reflect that the resident is at risk for elopement. In addition, the resident's care plan has been updated to address the resident's current risks for elopement including appropriate interventions. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a	

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	Resident B's most recent elopement risk assessment was completed on 6/20/24 and indicated resident was not at risk for elopement. Resident B's nurse's progress notes included the following: 7/20/2024 at 6:00 P.M. Nursing staff notified by aide from locked unit that resident had got out the front door. Nursing staff found resident out on sidewalk in wheelchair going to main building to get her recliner and bird feeders. Nursing staff brought resident back into building with no signs or symptoms of pain or injuries noted. Nursing staff tested front door and it came open and alarm went off. 7/21/2024 at 10:46 P.M. Resident has been looking for a way out of building all evening. 7/22/2024 at 1:14 P.M. Resident continues to be confused and continues to carry clothing on hangers in wheelchair about dayroom stating she is moving them but doesn't know where they need to go. Resident states she "found them in my closet." Staff able to redirect patient to place them back in her closet without difficulty. Patient also has been propelling about in facility, monitoring staff and exit door activity. Resident propelled down hallway toward garage doorway, but staff was able to redirect back to the dayroom. 2. On 8/29/24 at 11:05 A.M., LPN 3 indicated that Resident C was at risk for elopement and that staff kept an elopement binder with Resident C's photograph and information. On 8/29/24 at 11:40 A.M., Resident C's diagnoses included, but was not limited to, severe dementia with other behavioral disturbances and conduct		housewide review of all elopement risk assessments has now been conducted to identify the accuracy of the assessment and to identify each resident that is at risk for elopement. Those residents identified as an elopement risk have had their care plan reviewed and updated to include appropriate safety interventions which have been put in place to ensure the resident's safety. Additionally, the Elopement Policy and Procedures were reviewed by the IDT and updated to ensure risks are assessed appropriately based on an new risks that may arise. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's elopement risk policies and procedures. The staff have also been re-educated on the safety interventions to be followed to ensure the safety of those residents identified as elopement risk. The nursing staff have also been re-educated on their responsibility to ensure that elopement risk assessments are to be completed at least quarterly or with any current attempt of elopement, as well as to update the care plan with additional safety interventions when warranted. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a	

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	disorder. Resident C's most recent Admission MDS assessment, dated 8/6//24, indicated the resident had severe cognitive impairment and displayed behaviors of wandering during 1 - 3 days during a seven day review. Resident C's care plan included, but was not limited to, resident has behavior problem related to advanced dementia and conduct disorder as evidenced by combative with care and rejecting care (initiated 8/8/24) and resident has severely impaired cognitive function/impaired thought processes due to diagnosis of dementia. The most recently added interventions included but were not limited to, provide resident cueing, reorientation, and/or supervision as needed (initiated 7/30/24). No wandering or exit seeking behaviors were included in the resident's care plan. Resident C's most recent elopement risk assessment was completed on 7/30/24 and indicated a score of 2 and was "at risk" for elopement. Resident C's nurse's progress notes included the following: 8/4/2024 at 9:17 A.M. Resident is exit seeking and bothering other residents. Very confused and talking word salad. 8/7/2024 at 10:41 P.M. Resident exit seeking all evening shift. 8/16/2024 at 11:42 P.M. Resident wanders in to other patients rooms and difficult to redirect. Resident expressed want to go home.		Quality Assurance tool has been developed and implemented to monitor for compliance. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	8/22/2024 at 9:52 P.M. Resident is experiencing severe anxiety and agitation, wandering through the rooms and yelling loudly. He appears to be very confused and expresses a desire to see his wife. 8/25/2024 at 1:50 P.M. Resident propelling self in wheelchair talking to staff, visitors, and other residents. Interrupting visitors, trying to get into the kitchen, and pushed on front door setting the alarm off. During an interview on 8/29/24 at 11:55 A.M., LPN 7 indicated if a resident was showing new or increased exit seeking behaviors, staff should complete a new elopement risk assessment. If the assessment indicated that the resident was at risk for elopement, the plan of care should be updated to include new interventions for the behavior. During an interview on 8/29/24 at 12:55 P.M., Social Services 4 indicated that it would be appropriate for resident care plans to address specific behaviors including wandering and exit-seeking. On 8/29/24 at 12:55 P.M., Social Services 4 supplied a facility policy titled, Elopement Risk Policy and Procedure dated 12/19/15. The policy included, "...Purpose: To ensure that residents at risk for elopement are safe and have the necessary interventions in place to ensure their safety and well-being." On 8/29/24 at 1:10 P.M., the Director of Nursing (DON) supplied a facility policy titled, Behavioral Assessment, Intervention and Monitoring, dated 03/2019. The policy included, "Management 1. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of			

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	severity, distress and potential safety risk to the resident, and develop a plan of care accordingly." This citation relates to complaint IN00440331. 3.1-37(a)			