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	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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. This visit included the Investigation of Complaint IN00422200. Complaint IN00422200 - Federal/state deficiency related to the allegation is cited at F635. Survey dates: November 27, 28, 29, 30 and December 1, 4, 2023 Facility number: 000300 Provider number: 155539 AIM number: 1000287340 Census Bed Type: SNF/NF: 47 SNF: 3 Total: 50 Census Payor Type: Medicare: 6 Medicaid: 30 Other: 14 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 12,2023.	F 0000	December 21, 2023 Brenda Buroker Director Division of Long-Term Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Bertha D. Garten Ketcham Memorial Center Recertification and State Licensure Survey & Complaint Survey Survey Event ID Dear Ms. Buroker. On December 4, 2023, a Recertification and State Licensure Survey along with a complaint survey was conducted at our facility. 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 requests that the plan of correction be considered our allegation of compliance effective	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Wittmer	Administrator	12/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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			December 31, 2023, to the State findings of the Recertification and Licensure Survey and Complaint Survey conducted on December 4, 2023. We respectfully request a desk review to validate the facility's compliance to the findings of the Recertification and State Licensure Survey along with the Complaint Survey conducted on December 4, 2023. Please feel free to contact the facility if any additional information or documents are needed. . Respectfully submitted, ="" p="">"> Kathy Wittmer, HFA Bertha D Garten Ketcham Memorial Center	
F 0635 SS=D Bldg. 00	483.20(a) Admission Physician Orders for Immediate Care §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. Based on interview and record review, the facility failed to ensure each resident received physician ordered medications upon admission. A resident's medication was not continued after admission for 1 of 2 closed records reviewed. (Resident B)	F 0635	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We	12/05/2023

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	Finding includes: On 11/29/23 at 11:45 A.M., Resident B's clinical record was reviewed. The Admission MDS (Minimum Data Set) Assessment, dated, 9/21/23, indicated Resident B had a thyroid disorder. The most recent discharge MDS, dated 10/19/23, indicated Resident B was sent to the hospital. On 9/15/23 Resident B was admitted to the facility from the hospital. Upon admission to the facility, the hospital discharge orders, dated 9/15/23, included, but were not limited to: continue Synthroid (levothyroxine) 137 mcg by mouth daily. Current Physician's Orders lacked an order for Synthroid (levothyroxine) 137 mcg (micrograms) daily. A current Hypothyroidism Care Plan, dated 9/28/23, included, but was not limited to, the following intervention: Give my thyroid replacement therapy as ordered by my Dr (Doctor). See MAR (Medication Administration Record). Monitor/document/report PRN (as needed) any side effects and effectiveness. Date initiated 9/28/23. Progress notes included, but were not limited to, the following: 9/15/23 1:32 P.M. " ... Medications reviewed and verified with MD. Orders received. " 9/15/2023 6:00 P.M. "Dr. [name] here at this time to see and assess resident."		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 requests the plan of correction be considered our allegation of compliance effective (DATE) to the state findings of the Recertification and State Licensure Survey along with a Complaint Survey conducted on December 4, 2023. F - 635 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B no longer resides at this facility. No specific injuries resulted in the omission of the identified medication. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all new admissions for the past thirty days has been completed to ensure all admission orders were received and transcribed on the day of admission to the facility. No other omission in transcription or orders was identified. *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 licensed nurses on their responsibility to	

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	9/18/2023 8:30 A.M. "Received Dr. [name] initial physician visit from 8/15/2023. [sic] Progress notes received. Resident evaluated and assessed. Admission orders reviewed and signed off. No new orders received. The MAR (Medication Administration Record) indicated Resident B failed to receive Synthroid from 9/15/23 through 10/19/23 when she was discharged. During an interview on 11/29/23 at 2:58 P.M., the Administrator indicated Synthroid should have been ordered and it was human error. On 12/4/23 at 1:15 P.M., an undated, current Admission Policy and Procedure was provided by the Administrator and indicated, "...1. Admission Nurse-- will enter all admitting orders. Floor nurse to go over all orders with admission nurse for accuracy and initial off on medication list as being reviewed..." This citation relates to Complaint IN00422200. 3.1-30(a)		ensure all admission orders are accurately transcribed to the resident's clinical record upon admission. In addition, a second nurse will review and verify that all admission orders are correctly transcribed to the clinical record upon admission. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the transcription of admission orders. The tool will review all orders received upon admission to ensure that each order has been accurately transcribed to the resident's clinical record on the day of admission. 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 Quality Assurance meetings to determine if any additional action is warranted.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record	F 0641	F - 641	12/21/2023

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	review, the facility failed to accurately complete MDS (minimum data set) Assessments for 1 of 1 residents reviewed for Resident Assessment. (Resident 28) Finding includes: During an interview on 11/28/23 at 10:10 A.M., Resident 28 indicated she had never been on hospice, dialysis, a ventilator, or had a trach. On 11/28/23 at 2:57 P.M., Resident 28's medical record was reviewed. The most recent annual MDS, dated 10/28/23, indicated Resident 28 was cognitively intact and that she was on hospice care, received dialysis, had an invasive mechanical ventilator, and received tracheostomy care. During an interview on 11/29/23 at 2:56 P.M., the MDS Coordinator indicated Resident 28 was not on hospice care, dialysis, a ventilator, and she does receive tracheostomy care. At that time, she indicated those were all entered in error. She further indicated that the facility's policy is the follow the RAI (Resident Assessment Instrument) manual.		*The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 28 immediately had their MDS corrected and submitted. The previous information on the MDS had been submitted in error. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of each resident's most recent MDSs has been conducted to ensure the accuracy of each assessment. No other errors were identified during this review. *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 members of the interdisciplinary team on the importance of ensuring that all information entered into the MDS is accurate and reflects the resident's current condition. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the accuracy of the MDS. The tool will monitor each section of the MDS to ensure it reflects accurate information on the	

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			resident's condition and plan of care. 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 Quality Assurance meetings to determine if any additional action is warranted.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observation and interview, the facility failed to ensure proper storage of medications in 1 of 3 medication storage rooms and 2 of 5 medication carts. Narcotic boxes were not locked in the medication carts. Temperatures were not checked daily on a refrigerator storing resident immunizations and medications. Discontinued medications were stored in the storage rooms and not appropriately disposed. (West Hall) Findings include: 1. On 11/30/23 at 10:48 P.M., West Medication Cart 1 was observed with the narcotic box lid unlocked. The following medications were unlabeled in a drawer: Zinc Aspirin Senna Fruit Juice plus Turmeric Pepcid Magnesium Probiotic At that time, LPN (Licensed Practical Nurse) 16 indicated nursing staff knows those are Resident 99's medications. She brought those from home and they were kept by her other medications in the drawer. On 11/30/23 at 10:55 A.M., West Medication Cart 2 was observed with the narcotic box lid unlocked. At that time, QMA (Qualified Medication Aide) 5 indicated the narcotic box should be completely locked and she must have forgotten to close the lid. On 11/30/23 at 10:59 A.M., the West Hall storage	F 0761	F - 761 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the med cart identified a West Hall Med Cart 1 now has the narcotic drawer securely locked when not in use. The unlabeled medications belonging to the resident identified as resident 99 have now been destroyed as resident 99 no longer resides at the facility. The med cart identified as West Hall Med Cart 2 now has the narcotic drawer securely locked when not in use. The identified medications that were stored in the West Hall storage room have not been sent back to the pharmacy. The bag of identified medications belonging to the resident identified as resident 149 have now been destroyed. Resident 149 no longer resides at the facility. *2. The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents on the West Hall have the potential to be affected by this deficient practice. The temperatures on the West Hall Medication Storage Room refrigerator are now having the temperature recorded daily to ensure proper temperature control is maintained. *The corrective action taken for the other residents that have the*	12/07/2023

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	room was observed with the following inside: 1 storage box containing 1 blister pack with 30 pills of Melatonin 3 mg (milligram) and 1 blister pack with 11 pills of Lasix 20 mg. At that time, LPN 16 indicated both medications were discontinued and the pharmacy usually comes every night and was supposed to pick them up from staff. 1 bag of medications for Resident 149 included the following: Baclofen Gabapentin Loratadine Oxybutynin Tizanidine Duloxetine Trazadone Simethicone Zofran At that time, LPN 16 indicated Resident 149 was no longer in the facility and was not sure how long the medications had been there. She thought the DON (Director of Nursing) was responsible for disposing of the medications but was not sure. During an interview on 11/30/23 at 11:08 A.M., the DON indicated the son was aware the medications were there but he had not had time to pick them up yet and the facility won't destroy them because they were property of that resident. On 11/30/23 at 2:25 P.M., Resident 149's clinical record was reviewed and progress notes indicated she was discharged 11/6/23. 2. On 11/30/23 at 11:01 A.M., the West Hall Medication Storage Room refrigerator was observed with influenza vaccines and resident medications.		*potential to be affected by the same deficient practice is that* all residents have the potential be to affected by this deficient practice. A housewide audit of all medication carts and storage rooms has been completed to monitor for proper medication storage. All narcotic drawers are securely locked when not in use. All medications are properly labeled in accordance with the regulations. All discontinued medications are returned to the pharmacy or disposed of in accordance with the facility's drug destruction policy. The temperatures of all medication storage refrigerators are now recorded daily to ensure the proper temperatures are being maintained. *The measures that have been put into place to ensure that the deficient practice does not recur is that* the facility has revised their drug destruction policy from 48 hours to seven days to ensure proper time is available to destroy or return to the pharmacy all discontinued medications. A mandatory in-service has been provided for all licensed nurses and QMAs on the new revised drug destruction policy. The staff was also re-inserviced on the facility's medication storage policies with a focus on ensuring that narcotic drawers are securely locked when not in use.	

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	On 11/30/23 at 11:08 A.M., the West Hall Medication Storage Room Refrigerator temperature log was provided by LPN 16 and indicated temperatures were not documented on November 8, 13, 14, 15, 18, 19, 21, 22, 29. At that time, she indicated that the night shift nurses should check it every night and if it was not documented on there, there was no way to know if it was checked or not. On 12/4/23 at 12:00 P.M., a Medication Labeling policy, reviewed 5/12/21, was provided by the Administrator and indicated " ... the label may be affixed to an outside container or carton, but the resident's name, at minimum, must be maintained directly on the actual product container ... " On 12/4/23 at 12:00 P.M., a Storage of Controlled Medications Policy, reviewed 5/12/21, was provided by the Administrator and indicated " ... 4. Store all controlled substances and other medication(s) subject to abuse in a locked/secure cabinet or drawer, separate from all other medication(s). Schedule II controlled medication(s) are maintained within a separately locked, permanently affixed compartment .. " On 12/4/23 at 12:00 P.M., a Discharge Medications Policy, reviewed 5/12/21, was provided by the Administrator and indicated " ... 8. If medications were brought into the facility by a resident or responsible party and not returned or destroyed, the nurse returns these medications to the resident and documents return of the medications to the resident or responsible party along with other properly (sic) or valuables upon discharge ... " On 12/4/23 at 12:00 P.M., a Discontinued			

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	Medications Policy, reviewed 5/12/21, was provided by the Administrator and indicated " ... When medications are discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as "discontinued" and destroyed, or, if the packages are unopened, may be returned to the pharmacy within 48 hours ... " On 12/4/23 at 1:15 P.M., an undated Taking and Recording Temperatures of Refrigerators Policy was provided by the Administrator and indicated " ... 1. Evening/night shift nurse is responsible for taking and recording temperatures daily. 2. Temperatures will be recorded in log daily ... " 3.1-25(m)			
F 9999 Bldg. 00	5-4 FORM, REQUIREMENTS OF HEALTH FACILITY Sec. 4. A health facility shall do the following with the disclosure form required under section 3 of this chapter: (1) Submit the form to the division in December of each year. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a Alzheimer's/Dementia Special Care Unit disclosure was submitted to the state survey agency in December 2022. Findings include:	F 9999	F – 761 continued *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor medication storage. The tool will monitor to ensure all medications are properly labeled in accordance with the regulations, that all med cart narcotic drawers are locked securely when not in use, that all discontinued medications are disposed of or returned to the pharmacy in accordance with the facility's drug destruction policy and that temperatures are	12/29/2023

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	On 12/1/23 at 11:00 A.M., the Administrative Assistant indicated the facility had a memory care building on site. The Administrative Assistant indicated he was unsure if the facility had submitted a dementia disclosure form. The Administrator indicated she was unsure what the dementia disclosure form included. On 12/1/23 at 11:20 A.M., The (facility name) Dementia Care Small House Contract, dated 9/26/18, was provided by the Administrative Assistant and indicated " ... In order to provide for a therapeutic environment beneficial to the residents with Alzheimer's and related dementia disorders... the criteria below are applied: 1. Resident must have had thorough physical and appropriate diagnostic tests to rule out any treatable cause of the dementia prior to admission. 2. Residents must have a primary diagnosis of Alzheimer's disease or a related untreatable dementia ... " On 12/1/23 at 1:44 P.M., a completed Alzheimer's/Dementia Special Care Unit (State Form 48896) was provided by the Administrator, dated 12/1/23. She indicated they had completed and submitted the form to the state. During an interview on 12/04/23 at 11:49 A.M., the Administrator indicated they do not have a policy for the dementia disclosure agreement.		obtained daily on all med storage refrigerators. 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 Quality Assurance meetings to determine if any additional action is warranted.	