CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155539	B. WING	·	12/04/2023	
NAME OF F	PROVIDER OR SUPPLIER	•		ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	RO VIDER OR SOLVEIEN	•	601 E F	RACE ST		
BERTHA	D GARTEN KETCI	HAM MEMORIAL CENTER	ODON	, IN 47562		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	ID		(X5)	
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCT	DATE	
F 0000						
Bldg. 00						
		Recertification and State	F 0000	December 21, 2023		
	Licensure Survey.	This visit included the				
	Investigation of Co	mplaint IN00422200.		Brenda Buroker		
				Director Division of Long-Tern	n	
	Complaint IN00422	2200 - Federal/state deficiency		Care		
	-	tion is cited at F635.		Indiana State Department of		
				Health		
	Survey dates: Nove	mber 27, 28, 29, 30 and		2 North Meridian Street		
	December 1, 4, 202					
	December 1, 4, 202	3		Indianapolis, IN 46204		
	Facility number: 00	0300		RE: Bertha D. Garten Ketcha	m	
	Provider number: 1			Memorial Center	"	
	AIM number: 1000			-		
	Alivi number: 1000.	28/340		Recertification and State		
	a n.m			Licensure Survey & Complain	t	
	Census Bed Type:			Survey		
	SNF/NF: 47			Survey Event ID		
	SNF: 3					
	Total: 50					
				Dear Ms. Buroker.		
	Census Payor Type	:				
	Medicare: 6			On December 4, 2023, a		
	Medicaid: 30			Recertification and State		
	Other: 14			Licensure Survey along with a	ı [	
	Total: 50			complaint survey was conduct		
				at our facility. By submitting th		
	These deficiencies	reflect State Findings cited in		enclosed material, we are not		
	accordance with 41	_		1		
	accordance with 41	0 11 1C 10.2-3.1.		admitting the truth or accuracy	, oi	
	Ovalit'	mloted on Decamber 12 2022		any specific findings or		
	Quality review com	pleted on December 12,2023.		allegations. We reserve the rig	<sup>jnt</sup>	
				to contest the findings or		
				allegations as part of any		
				proceedings and submit these	;	
				responses pursuant to our		
				regulatory obligations. The fac	cility	
				requests that the plan of		
				correction be considered our		
				allegation of compliance effec	tive	
			1	1		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Kathy Wittmer Administrator 12/21/2023

Any defiency statement 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 disclodays 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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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	X3) DATE SURVEY COMPLETED 12/04/2023
	PROVIDER OR SUPPLIE	R CHAM MEMORIAL CENTER	601 E	ADDRESS, CITY, STATE, ZIP COD RACE ST I, IN 47562	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				December 31, 2023, to the Sta findings of the Recertification a Licensure Survey and Complai Survey conducted on December 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 feet 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	nd nt er 4, ne e n
F 0635 SS=D Bldg. 00	Care §483.20(a) Admis At the time each	resident is admitted, the physician orders for the			
	Based on interview failed to ensure eac ordered medication medication was no	y and record review, the facility th resident received physician as upon admission. A resident's t continued after admission for ds reviewed. (Resident B)	F 0635	By submitting the enclosed materials, we are not admitting truth or accuracy of any specififindings or allegations. We	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155539	B. W	B. WING		12/04/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			RACE ST		
REDTUA	D GARTEN KETCH	HAM MEMORIAL CENTER					
DERIMA	D GANTEN KETC	I IAW WEWORIAL CENTER		ODON, IN 47562			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					reserve the right to contest the		
	Finding includes:				findings or allegations as part		
					any proceedings and submit the	nese	
		45 A.M., Resident B's clinical			responses pursuant to our		
	record was reviewe				regulatory obligations. The fa	-	
		OS (Minimum Data Set)			requests the plan of correction	be	
		9/21/23, indicated Resident B			considered our allegation of		
	•	der. The most recent discharge			compliance effective		
	· ·	23, indicated Resident B was			(DATE) to the state		
	sent to the hospital.				findings of the Recertification		
	O:: 0/15/22 B : 1	4 D			State Licensure Survey along		
		nt B was admitted to the facility			a Complaint Survey conducted	on c	
	-	Jpon admission to the facility,			December 4, 2023.		
	-	ge orders, dated 9/15/23,			F - 635		
	included, but were				The corrective action taken for	r	
	-	(levothyroxine) 137 mcg by			those residents found to have		
	mouth daily.				been affected by the deficient		
	C DI C	01111116			practice is that the resident		
		Orders lacked an order for			identified as resident B no long	-	
		roxine) 137 mcg (micrograms)			resides at this facility. No spe		
	daily.				injuries resulted in the omission	on ot	
	A assumant Harmatharin	widiam Cara Dlam datad			the identified medication.	410 -	
		roidism Care Plan, dated but was not limited to, the	The corrective action taken for the				
	following intervent				other residents that have the		
	-	placement therapy as ordered			potential to be affected by the same deficient practice is that		
	by my Dr (Doctor).				housewide audit of all new	а	
	• • •	ion Administration Record).				dave	
		report PRN (as needed) any			admissions for the past thirty of has been completed to ensure	-	
	side effects and effe				admission orders were receive		
	Date initiated 9/28/2				and transcribed on the day of	<b>.</b> u	
	Date initiated 7/20/.	<del>-</del> 2.			admission to the facility. No o	ther	
	Progress notes inch	uded, but were not limited to,			omission in transcription or ord		
	the following:	acce, sat were not ininiou to,			was identified.	4010	
	_	' Medications reviewed and			The measures that have been	put	
	verified with MD. (				into place to ensure that the	Par	
					deficient practice does not rec	ur is	
	9/15/2023 6:00 P M	I. "Dr. [name ] here at this time			that a mandatory in-service ha		
	to see and assess re				been provided for all licensed		
	15 500 and abbods for				nurses on their responsibility t	•	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 12/04/2023
	PROVIDER OR SUPPLIER  D GARTEN KETCHAM MEMORIAL CENTER	601 E F	ADDRESS, CITY, STATE, ZIP COD RACE ST 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 APPROPRIA DEFICIENCY)	DATE
	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 ar accurately transcribed to the resident's clinical record upon admission. In addition, a seconurse will review and verify the admission orders are correctly transcribed to the clinical recoupon admission.  The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has be developed and implemented to monitor the transcription of admission orders. The tool wireview all orders received upo 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 quarters. Toutcome of this tool will be reviewed at the facility Quality Assurance meetings to determ if any additional action is warranted.	and at all rd en b II n
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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 $HGWV11 \quad \text{Facility ID:} \quad 000300$ 

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155539	B. W	ING		12/04/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
DEDTILA	D CARTEN KETO	LIANA MENAODIAL OFNITED			RACE ST		
BERTHA	D GARTEN KETCI	HAM MEMORIAL CENTER		ODON,	IN 47562		
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	review, the facility	failed to accurately complete			The corrective action taken for	r	
	MDS (minimum da	ta set) Assessments for 1 of 1			those residents found to have		
	residents reviewed	for Resident Assessment.			been affected by the deficient		
	(Resident 28)				practice is that the resident		
					identified as resident 28		
	Finding includes:				immediately had their MDS		
	_				corrected and submitted. The		
	During an interview	on 11/28/23 at 10:10 A.M.,			previous information on the M		
	Resident 28 indicate	ed she had never been on			had been submitted in error.		
		ventilator, or had a trach.			The corrective action taken for	r the	
					other residents that have the		
	On 11/28/23 at 2:57	P.M., Resident 28's medical			potential to be affected by the		
	record was reviewe	d. The most recent annual			same deficient practice is that	all	
	MDS, dated 10/28/2	23, indicated Resident 28 was			residents have the potential to		
		nd that she was on hospice			affected by this deficient pract		
	care, received dialy	sis, had an invasive			A housewide audit of each		
	mechanical ventilat	or, and received tracheostomy			resident's most recent MDSs I	nas	
	care.				been conducted to ensure the		
					accuracy of each assessment		
	During an interview	on 11/29/23 at 2:56 P.M., the			No other errors were identified		
	MDS Coordinator is	ndicated Resident 28 was not			during this review.		
	on hospice care, dia	llysis, a ventilator, and she			The measures that have been	put	
	does receive trached	ostomy care. At that time, she			into place to ensure that the	-	
	indicated those wer	e all entered in error. She			deficient practice does not rec	ur is	
	further indicated that	at the facility's policy is the			that a mandatory in-service ha	ıs	
	follow the RAI (Res	sident Assessment Instrument)			been provided for all members	s of	
	manual.				the interdisciplinary team on th	ne	
					importance of ensuring that all		
					information entered into the M	DS	
					is accurate and reflects the		
					resident's current condition.		
					The corrective action taken to		
					monitor to ensure the deficien	t	
					practice will not recur is that a		
					Quality Assurance tool has be	en	
					developed and implemented to	o	
					monitor the accuracy of the M	DS.	
					The tool will monitor each sec	tion	
					of the MDS to ensure it reflect	s	
					accurate information on the		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	 ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 12/04/	ETED
	PROVIDER OR SUPPLIER D GARTEN KETCH	HAM MEMORIAL CENTER	601 E R	ADDRESS, CITY, STATE, ZIP COD AACE ST IN 47562		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
				resident's condition and plan of care. This tool will be completed by the Director of Nursing and 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.	ed /or of	
F 0761 SS=E Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accepted	and Biologicals and of Drugs and Biologicals cals used in the facility accordance with currently conal principles, and include cessory and cautionary ane expiration date when				
	§483.45(h)(1) In a Federal laws, the and biologicals in under proper temp	e of Drugs and Biologicals ccordance with State and facility must store all drugs locked compartments perature controls, and ized personnel to have				
	separately locked, compartments for listed in Schedule Drug Abuse Preve 1976 and other drug except when the fapackage drug distributed.	facility must provide permanently affixed storage of controlled drugs II of the Comprehensive ention and Control Act of ugs subject to abuse, acility uses single unit ribution systems in which I is minimal and a missing				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155539	B. W	ING		12/04/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			RACE ST		
   BERTHA	D GARTEN KETO	CHAM MEMORIAL CENTER			IN 47562		
DEIXIIIA	BERTHALD SARTER RETORNAM MEMORIAL SERVICE			ODON,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	dose can be read						
	Based on observat	ion and interview, the facility	F 0'	761	F - 761		12/07/2023
	failed to ensure pro	oper storage of medications in 1			The corrective action taken for	r	
	of 3 medication sto	orage rooms and 2 of 5			those residents found to have		
	medication carts.	Narcotic boxes were not locked			been affected by the deficient		
	in the medication of	earts. Temperatures were not			practice is that the med cart		
	checked daily on a	refrigerator storing resident			identified a West Hall Med Ca	rt 1	
	immunizations and	l medications. Discontinued			now has the narcotic drawer		
	medications were	stored in the storage rooms and			securely locked when not in us	se.	
	not appropriately of	lisposed. (West Hall)			The unlabeled medications		
					belonging to the resident ident	tified	
	Findings include:				as resident 99 have now been	l	
			destroyed as resident 99		nger		
1. On 11/30/23 at 10:48 P.M., West Medication			resides at the facility. The r		d		
	Cart 1 was observe	ed with the narcotic box lid		cart identified as West Hall Med		ed	
	unlocked.		Cart 2 now has the narcotic				
	The following med	dications were unlabeled in a			drawer securely locked when	not	
	drawer:				in use. The identified medicat	ions	
	Zinc				that were stored in the West F	lall	
	Aspirin				storage room have not been s	ent	
	Senna				back to the pharmacy. The ba	ag of	
	Fruit Juice plus				identified medications belongi	ng to	
	Turmeric				the resident identified as resid	ent	
	Pepcid				149 have now been destroyed	l.	
	Magnesium				Resident 149 no longer reside	s at	
	Probiotic				the facility.		
		(Licensed Practical Nurse) 16			2. The corrective action taken	for	
	indicated nursing s	staff knows those are Resident			those residents found to have		
	99's medications. S	She brought those from home			been affected by the deficient		
	and they were kept	t by her other medications in			practice is that all residents or	n the	
	the drawer.				West Hall have the potential to	be be	
					affected by this deficient pract	ice.	
	On 11/30/23 at 10:	55 A.M., West Medication Cart			The temperatures on the Wes	t	
	2 was observed wi	th the narcotic box lid unlocked.			Hall Medication Storage Roon	า	
	At that time, QMA	(Qualified Medication Aide) 5			refrigerator are now having the	е	
	indicated the narco	tic box should be completely			temperature recorded daily to		
	locked and she mu	st have forgotten to close the			ensure proper temperature co	ntrol	
	lid.				is maintained.		
					The corrective action taken for	r the	
	On 11/30/23 at 10:	59 A.M., the West Hall storage			other residents that have the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155539	B. W	ING		12/04/2023	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			RACE ST		
   RERTH∆	D GARTEN KETC	HAM MEMORIAL CENTER			IN 47562		
DEIXIIIA	- DOANTEN NETO	I I AN INCINIONAL OLIVILIA		ODON,	111 77 002		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		1	TAG	DEFICIENCY)		DATE
		with the following inside:			potential to be affected by the		
		ining 1 blister pack with 30			same deficient practice is that		
	1 ~	3 mg (milligram) and 1 blister			residents have the potential be		
	pack with 11 pills o	_			affected by this deficient pract	ice.	
		6 indicated both medications			A housewide audit of all		
		and the pharmacy usually			medication carts and storage		
		and was supposed to pick			rooms has been completed to		
	them up from staff.				monitor for proper medication		
					storage. All narcotic drawers		
	_	ns for Resident 149 included the			securely locked when not in us	se.	
	following:				All medications are properly		
	Baclofen				labeled in accordance with the	;	
	Gabapentin				regulations. All discontinued		
	Loratadine				medications are returned to th	е	
	Oxybutynin				pharmacy or disposed of in		
	Tizanidine				accordance with the facility's o	drug	
	Duloxetine				destruction policy. The		
	Trazadone				temperatures of all medication	1	
	Simethicone Zofran				storage refrigerators are now		
		( :- 1: 1 D: 1 140			recorded daily to ensure the		
		6 indicated Resident 149 was ility and was not sure how			proper temperatures are being	3	
	_	ins had been there. She thought			maintained.	nut.	
	_	of Nursing) was responsible for			The measures that have been	ραι	
		edications but was not sure.			into place to ensure that the	ur io	
		on 11/30/23 at 11:08 A.M., the			deficient practice does not rec that the facility has revised the		
	_	son was aware the medications			drug destruction policy from 4		
		ad not had time to pick them			hours to seven days to ensure		
		ity won't destroy them because			proper time is available to des		
	they were property	-	1		or return to the pharmacy all	аоу	
	ale, were property	or man resident			discontinued medications. A		
	On 11/30/23 at 2·25	5 P.M., Resident 149's clinical			mandatory in-service has been	n	
		d and progress notes indicated			provided for all licensed nurse		
	she was discharged				and QMAs on the new revised		
	lgod				drug destruction policy. The s		
	2. On 11/30/23 at 1	1:01 A.M., the West Hall			was also re-inserviced on the		
		Room refrigerator was			facility's medication storage		
	_	enza vaccines and resident			policies with a focus on ensuri	na	
	medications.				that narcotic drawers are secu	-	
					locked when not in use.	5.,	
	I		1		1 .55.154 11.1511 1101 111 400.		

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	te survey ipleted 04/2023
	PROVIDER OR SUPPLIER D GARTEN KETCI	HAM MEMORIAL CENTER	601 E	ADDRESS, CITY, STATE, ZIP C RACE ST , IN 47562	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR On 11/30/23 at 11:0 Medication Storage	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 08 A.M., the West Hall Room Refrigerator s provided by LPN 16 and	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	indicated temperatu November 8, 13, 14 time, she indicated should check it even	res were not documented on 1, 15, 18, 19, 21, 22, 29. At that that the night shift nurses ry night and if it was not re, there was no way to know if				
	policy, reviewed 5/ Administrator and i affixed to an outside resident's name, at 1	9 P.M., a Medication Labeling 12/21, was provided by the ndicated " the label may be e container or carton, but the minimum, must be maintained al product container "				
	Medications Policy, provided by the Ad. 4. Store all controlle medication(s) subjectabinet or drawer, semedication(s). Schemedication(s) are medication(s) are medication(s).	P.M., a Storage of Controlled reviewed 5/12/21, was ministrator and indicated " ed substances and other ct to abuse in a locked/secure eparate from all other dule II controlled naintained within a separately y affixed compartment "				
	Policy, reviewed 5/ Administrator and i were brought into the responsible party are the nurse returns the resident and docum to the resident or re-	9 P.M., a Discharge Medications 12/21, was provided by the indicated " 8. If medications he facility by a resident or and not returned or destroyed, esse medications to the ents return of the medications sponsible party along with or valuables upon discharge				
	On 12/4/23 at 12:00	P.M., a Discontinued				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00  B. WING		COMPLETED 12/04/2023	
		155539	B. WI	NG		12/04/	2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BERTHA	D GARTEN KETCI	HAM MEMORIAL CENTER			IN 47562		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	Medications Policy, provided by the Adr When medications a prescriber, a resider and does not take m the event of a reside are marked as "disc the packages are un the pharmacy within On 12/4/23 at 1:15 Recording Tempera was provided by the " 1. Evening/nightaking and recording	exercised 5/12/21, was ministrator and indicated " are discontinued by a ministrator with him/her, or in ent's death, the medications ontinued" and destroyed, or, if opened, may be returned to may be		TAG	DEFICIENCY		DATE
F 9999							
Bldg. 00	FACILITY Sec. 4. A health fac the disclosure form this chapter: (1) Submit the form each year.  This State rule was Based on interview failed to ensure a A	REMENTS OF HEALTH  ility shall do the following with required under section 3 of  to the division in December of  not met as evidenced by:  and record review, the facility lzheimer's/Dementia Special e was submitted to the state ecember 2022.	F 99	999	F – 761 continued The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has be developed and implemented to monitor medication storage. Tool will monitor to ensure all medications are properly label in accordance with the regulations, that all med cart narcotic drawers are locked securely when not in use, that discontinued medications are disposed of or returned to the pharmacy in accordance with facility's drug destruction policiand that temperatures are	en o The ed all	12/29/2023

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER BERTHA D GARTEN KETCHAM MEMORIAL CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYTON GENERAL DEFINITION OF DATE DATE of the Administrative Assistant indicated the was unsure if the facility had submitted a 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 the Administrative Assistant and Indicated the The Administrative Assistant and Indicated the The Administrative Assistant Administrative Assistant Administrative Assistant Indicated the Was unsure what the Provide for a therapeutic environment beneficial to the residents with Alzheimer's and related dementia disorders. The Outcome of this tool will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.  PREFETX TAG DOWN THE PROVIDED TO A The Provide Tag Down The Administrative Assistant Indicated the The Administrative Assistant Indicated the Was United The Pr	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
NAME OF PROVIDER OR SUPPLIER  BERTHA D GARTEN KETCHAM MEMORIAL CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH) DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR ISC IDENTIFYING INFORMATION  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 the was unsure if the facility had submitted a dementia disclosure form. The Administrative 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	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLE	COMPLETED	
BERTHA D GARTEN KETCHAM MEMORIAL CENTER  (X4) ID PREFIX TAG  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  601 E RACE ST ODON, IN 47562  DD PREFIX TAG  DD PREFIX TAG  PROVIDERS PLANOF COGRECTIVE.  PREFIX TAG  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.  Substantian discovers 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			155539	B. WING		12/04/2023		
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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.	170	On 12/1/23 at 11:00 Assistant indicated building on site. The indicated he was unsubmitted a demental Administrator indicated he was unsubmitted a demental disclosure.  On 12/1/23 at 11:20 Dementia Care Sma 9/26/18, was provided Assistant and indicate for a therapeutic enteresidents with Alzh disorders the crited Resident must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cause of the 2. Residents must have appropriate diagnost treatable cau	DA.M., the Administrative the facility had a memory care the Administrative Assistant assure if the facility had the dia disclosure form. The the facility had the dia disclosure form. The the facility name what the the form included.  DA.M., The (facility name) all House Contract, dated ded by the Administrative the did " In order to provide the vironment beneficial to the the eimer's and related demential the did thorough physical and the demential prior to admission. The		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 quarterly for three quarters. Toutcome of this tool will be reviewed at the facility Quality Assurance meetings to determ if any additional action is	then he	DAIL	

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