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	10/10/2024

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

(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. Survey dates: October 3, 4, 7, 8, 9, and 10, 2024 Facility number: 000300 Provider number: 155539 AIM number: 100287340 Census Bed Type: SNF: 3 SNF/NF: 53 Total: 56 Census Payor Type: Medicare: 3 Medicaid: 35 Other: 18 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 22, 2024.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to notify and consult the physician, resident, and/or resident's representative of changes that may require an alteration in the resident's care for 2 of 5 residents reviewed for unnecessary medications. The physician, resident, and/or resident's representative were not notified of a resident's missed medication dose and a resident's weight loss. (Resident 4, Resident	F 0580	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 any proceedings and submit these responses pursuant to our regulatory obligations. The facility	11/19/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Millikan	Administrator	11/04/2024

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.

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	10/10/2024

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

(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
	15) Findings include: 1. On 10/8/24 at 9:28 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, hemiplegia left non-dominant side, and anxiety. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/15/24, indicated Resident 4's cognition was not able to be assessed, she was totally dependant on 2 staff for bed mobility, transfers, toileting, and totally dependant on 1 staff for eating. Her height was 62 inches and her weight was 149 lbs (pounds). A current Nutritional Care Plan, revised 10/8/24, included, but was not limited to the following intervention: Keep my MD (Medical Doctor) and RD (Registered Dietitian) informed of any weight gains or losses of 5 lbs or more in 30 days, initiated 9/14/23 Resident 4's weights were reviewed and indicated: On 4/3/24 at 9:06 A.M., 159.1 lbs On 5/5/24 at 5:06 A.M., 153.4 lbs (down 5.7 lbs in 31 days) Progress notes were reviewed from 4/4/24 through 10/8/24 and lacked documentation of the MD, RD, or family being notified of the weight loss that occurred between 4/4/24 and 5/5/24. During an interview on 10/9/24 at 12:27 P.M., the DON (Director of Nursing) indicated notification about the weight loss should have been made to the MD and family, should have been done right away, and documented in a progress note.		requests the plan of correction be considered our allegation of compliance effective November 19, 2024 to the state findings of the Recertification and State Licensure Survey conducted on October 10, 2024. F - 580 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 4 now has documentation in the clinical record to support that the resident's physician and responsible party have been notified of the resident's recent weight loss along with the interventions that have been put in place to address this concern. The resident will continue to be monitored for any additional weight loss and the physician and the resident's representative will be promptly notified of any additional weight loss issues. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 15 is now receiving all medications and treatments as ordered by their physician. If in the future, any medication and/or treatment is refused or not provided as ordered, the physician will be promptly notified and the notification documented in the clinical record.	

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	10/10/2024

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

(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
	2. On 10/9/24 at 9:00 A.M., Resident 15's clinical record was reviewed. Diagnosis included, but were not limited to, dementia with behaviors, anxiety, and depression. The most recent Annual MDS Assessment, dated 7/18/24, indicated a severe cognitive impairment, and required extensive assistance of two staff with bed mobility, transfers, and toileting. Resident 15 was currently taking an antipsychotic. Current physician orders included, but were not limited to: olanzapine (Zyprexa) (an antipsychotic) 10mg (milligrams) one time a day related to vascular dementia with psychotic disturbance and depression, dated 10/9/24. Other physician orders included, but were not limited to: olanzapine 5mg at bedtime related to depression, anxiety, and vascular dementia, dated 1/5/24 and discontinued 10/8/24. A current care plan, revised 9/1/23, indicated Resident 15 took a routine antipsychotic medication as behavioral management related to a diagnosis of depression, anxiety, and dementia with psychotic disturbances. Interventions included, but were not limited to: IDT (Interdisciplinary Team), pharmacy, and my physician to consider dosage reduction when clinically appropriate at least quarterly, dated 7/20/22. A nursing note, dated 10/8/24 at 12:33 P.M., indicated a new order was given by the physician to increase Zyprexa to 10mg.		In addition, the facility now has a policy on medication administration which addresses physician notification of any missed or refused doses. *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. The facility has now conducted an audit of all resident's weight to ensure that any significant weight variances have been reported to their respective attending physician as well as their representative. In addition, a housewide audit of all MARs/TARs has been conducted to ensure that all medications and treatment have been provided as ordered by the physician. Any refusals and/or missed doses have been reported to the physician and the notification of the missed doses have been documented in the clinical record. *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 and QMAs on the facility's policy related to physician notification of any refused and/or missed medications/treatments. In addition, the nursing staff along with the food service manager have been re-educated on their	

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	10/10/2024

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

(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
	Resident 15's MAR (Medication Administration Record) from October 2024 indicated Zyprexa 5mg had been given daily at bedtime from 10/1/24 through 10/7/24. A new order for Zyprexa 10mg daily had been started on 10/9/24 and given at 8:00 A.M. Resident 15 had not been given a dose of Zyprexa on 10/8/24. The clinical record lacked acknowledgment of the missed dose of Zyprexa on 10/8/24, notification to the physician to clarify the order, or notify of the missed day. On 10/9/24 at 12:10 P.M., the DON indicated staff should clarify medication changes and new orders if need. She indicated when a dosage is changed, the new order would be put in for the same time of day unless the physician indicated specifically that the new dose needed to be given at a different time. She further indicated she did not have an answer for why Resident 15 was not given a dose of Zyprexa on 10/8/24, only that's how it was generated in the computer when the new order was put in. She indicated she was unsure if staff should have put the order in differently, considered it a missed medication dose, and that the physician should have been notified. On 10/9/24 at 12:55 P.M., a current Notification Policy was requested and not provided. 3.1-5(a)(3)		responsibility to notified the physician and the resident's representative of any significant weight variances and to document this notification in the clinical record. F – 580 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 compliance in the documenting of physician and representative notification of any significant weight variance. In addition, the tool will monitor to ensure that any missed or refused doses of medications and/or treatments has been promptly reported to the physician and that the notification is documented in the clinical record. 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.	
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record	F 0656	F - 656	11/19/2024

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	10/10/2024

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

(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
	review, the facility failed to develop a person centered comprehensive care plan for 3 of 5 residents reviewed for unnecessary medications and 1 of 2 residents reviewed for accidents. Resident's who were on an antiplatelet medication, a diuretic medication, EBP (Enhanced Barrier Precautions), contact isolation, and a fall did not have care plans developed or revised. . (Resident 16, Resident 36, Resident 20) Findings include: 1. On 10/8/24 at 4:37 P.M., Resident 16's clinical record was reviewed. Diagnoses included, but were not limited to, Atrial Fibrillation, hypertension, and coronary artery disease. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/4/24 indicated Resident 16 received a diuretic medication. Physician Orders included, but were not limited to, hydrochlorothiazide tablet (diuretic) 25mg (milligrams), give 1 tablet a day for high blood pressure, start date 10/11/23. Resident 16's clinical record lacked a care plan for a diuretic. 2. On 10/7/24 at 10:15 A.M., Resident 36's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, anxiety disorder, and depression. The most recent Quarterly MDS Assessment, dated 8/7/24 indicated Resident 36 was cognitively intact and required a limited assistance of 1 staff member for bed mobility, transfers, and toileting.		*1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 16 now has a care plan developed and implemented related to the use of a diuretic medication. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 36 has now had their care plan updated to include additional interventions in an attempt to prevent future falls. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 20 has now had their care plan updated to reflect the use of an antiplatelet medication as well as the resident's current need for isolation. *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 all care plans has been completed to ensure that each resident's care plan addresses their current needs and concerns, including the monitoring in the use of specific medications, new fall interventions following each fall as well as any	

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	10/10/2024

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

(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
	Care plans included, but were not limited to, an at risk for falls with interventions for the following: --encourage me to wear non skid footwear at all times, dated 12/15/22 --I will use rolling walker while ambulating, dated 10/9/24 --if a fall should occur, complete root cause analysis to alleviate or minimize reason for fall, dated 12/15/22 --keep my bed at safest height for transfer - the top arch of the headboard even with the bottom of the --decal on the wall at head of bed. Decal placed by therapy for optimum transfer height, dated 12/15/22 --keep my call light and frequently used personal item within reach, dated 12/15/22 --my family prefers I wear lace up shoes instead of slip on shoes, dated 7/11/23 --My nurse will perform fall risk assessment upon admission, quarterly, and as needed with any significant changes or with occurrence of any falls, dated 12/15/22 --perform frequent checks for safety, dated 12/15/22 --refer to physical and occupational therapy as needed, dated 12/15/22 On 7/14/24 at 10:13 A.M., an incident note was in Resident 36's progress notes that indicated, "CNA [Certified Nurse Aide] stated resident was walking and tripped over her sandals in hallway. CNA only witnessed prior to landing. Nurse (in other building) found resident sitting on her bottom with CNA present. VS [vital signs] and neuro [neurological] checks WNL [within normal limits]. No complaints of pain." During an interview on 10/9/24 at 10:11 A.M., the DON (Director of Nursing) indicated Resident 36's care plan should have been updated after her fall		specific type of precautions/isolation needed to address any medical conditions. All residents care plans are now complete and current to address all of the resident's needs. *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 facility's care planning process. The team was instructed on the importance on ensuring that all residents' needs and concerns are properly care planned in a timely manner. *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 and completeness of the resident's care plans to ensure that each of the resident's needs and concerns has been identified and care planned with appropriate interventions. This tool will be completed by the MDS coordinator 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.	

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	10/10/2024

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

(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
	on 7/14/24. 3. On 10/3/24 at 2:32 P.M., Resident 20 was observed sitting in the recliner in his room with a catheter and bandages on his right lower extremity. On 10/8/24 at 1:03 P.M., Resident 20's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, hemiplegia affecting left non-dominant side, unspecified escherichia coli, pseudomonas, proteus mirabilis, MRSA (Methicillin susceptible staphylococcus aureus), skin infection, and peripheral vascular disease. The most recent Quarterly MDS Assessment, dated 8/3/24, indicated Resident 20 was cognitively intact, had an indwelling catheter, and had wounds. The MDS Assessment did not indicate Resident 20 was taking an Antiplatelet medication. Current Physician's Orders included, but were not limited to, the following: Appointment with urology nurse at (name of office) on 11/5/24 at 10:45 A.M., for catheter change Catheter care: Inspect meatus for redness, irritation, and/or drainage. Assess the catheter at insertion site for encrusted material and drainage. Wash peri (perineal) area and catheter with mild soap and water (make sure to hold catheter in place while cleaning so that it does not become dislodged). Pat dry with sterile cloth/gauze. Monitor that securement device is in place (change if needed). Monitor that catheter is draining adequately and that drainage bag is hanging below bladder every day and night shift, ordered 8/15/24			

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	10/10/2024

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

(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
	Clean bilateral legs with wound cleaner, pat dry. Apply Aquaphor ointment to bilateral lower legs and feet. Wrap with kerlix/roller gauze. Apply ACE bandage if resident allows every day shift, ordered 8/21/24 Clean wound to lateral lower left extremity with wound cleanser, pat dry; apply calcium alginate; cover with dressing of choice every day shift, ordered 9/18/24 Clean wounds to lateral right lower extremity with wound cleanser. Pat dry. Apply calcuim alginate wound dressing that absorbs excess moisture to promote healing) and an ABD (abdominal gauze)pad. Wrap with kerlix/roller gauze. May apply ACE wraps if resident allows every day shift, ordered 8/21/24 Cleanse wound to right lateral foot with wound cleanser; allow/pat dry; cover wound bed with calcium alginate; cover with dressing of choice every day shift, ordered 9/13/24 Resident requires contact precautions due to positive wound culture, ordered 10/1/24 Cilostazol 50 mg (milligram) tablet, give 1 tablet by mouth two times a day, ordered 8/15/24 The clinical record lacked a care plan for an antiplatelet medication, need for EBP (Enhanced Barrier Precautions), and contact isolation. During an interview on 10/9/24 at 9:31 A.M., the MDS Coordinator indicated that when new orders were put in for residents, they were discussed the next day at morning meeting and care plans should be added at that time. The diuretic for Resident 16 must have been missed, but there			

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	10/10/2024

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

(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
	should be a care plan for that. She was unaware the medication, Cilostazol (an antiplatelet), was an antiplatelet and missed putting it on the MDS Assessment and therefore it was not triggered that a care plan was needed; However, there should be one in place. At that time, the DON indicated Resident 20 needed to be on EBP (Enhanced Barrier Precautions) for wound and catheter care, and recently contact isolation because his wound culture came back positive and he should have been care planned for these precautions. On 10/9/24 at 2:12 P.M., a current Care Planning Policy, dated March 2022, was provided by the DON and indicated " The interdisciplinary team is responsible for the development of resident care plans ... are developed according to the time frames and criteria ... " On 10/9/24 at 2:12 P.M., a current Comprehensive Care Plan Policy, dated March 2022, was provided by the DON and indicated " ... The IDT team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident ... Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change ... the IDT team reviews and updates the care plan ..." 3.1-35(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure adequate supervision and assistance devices were provided	F 0689	F - 689 *The corrective action taken for those residents found to have*	11/19/2024

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	10/10/2024

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

(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
	to prevent accidents for 1 of 2 residents reviewed for falls. A resident's care plan was not updated timely with a new intervention after her first fall and the resident fell again with the intervention not being in place at the time of the fall. (Resident 15) Finding includes: On 10/9/24 at 9:16 A.M., Resident 15 was observed sitting in the recliner in her room with oxygen on per nasal cannula and a pull tab alarm attached to her left shoulder. On 10/8/24 at 3:17 P.M. Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, history of falling, and muscle weakness. The most recent Annual MDS (Minimum Data Set) Assessment, dated 7/18/24, indicated Resident 15's cognition was severely impaired and an extensive assist of 2 staff for bed mobility, transfers, toileting, had 2 falls, and no alarms were used. Current Physician's Orders included, but were not limited to, the following: May have pull tab alarm (string attached to resident that triggers alarm alerting staff) in place while in bed and in recliner. Check for placement and proper functioning every day and night shift, dated 8/7/24 May have pressure alarm to bed to alert staff of rising unassisted to be checked every day and night shift for proper functioning, dated 8/27/24 A current Risk for Falls Care Plan, revised 8/7/24, included, but was not limited to, the following		*been affected by the deficient practice is that* the resident identified as resident 15 has been reviewed by the interdisciplinary team related to fall risks and interventions. The resident's fall risk care plan is now current and contains appropriate safety interventions in an attempt to prevent future falls. No additional falls has occurred since the fall of 06-20-24. Upon observation of the resident all safety interventions are currently in place in accordance with the care plan. In addition, the CNA assignment sheets reflect the resident's current safety interventions. *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. All residents' fall risks factors have now been reviewed by the interdisciplinary team. Each resident has appropriate safety interventions care planned to address their safety risks. Upon observation of each resident identified as a safety/fall risk, their safety interventions are in place in accordance with their individualized care plan. Upon review of the CNA assignment sheets, each resident's safety interventions have been listed on the CNA assignment sheet. The care plans and CNA assignment	

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	10/10/2024

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

(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
	interventions: I require a pull tab alarm to be used while I am in bed and up in recliner to ensure my safety and remind me not to get up unassisted, initiated 8/7/24 Fall 1 On 6/1/24 at 4:30 A.M., an Incident Note indicated a CNA (Certified Nurse Aide) heard someone yell for help upon entering room and found resident sitting on buttocks between air conditioner and bed. A pull alarm was placed on resident as a fall intervention at that time. A post fall risk evaluation indicated resident was high risk for falls. The order for the alarm and the care plan were not updated in the resident's chart. Fall 2 On 6/20/24 at 7:45 P.M., a health status note indicated a QMA (Qualified Medication Aide) alerted nurse that resident was lying in the floor and had fallen and hit her head. "She had attempted to rise from recliner unassisted and busted her head on the floor resulting in a significant gash to her forehead with moderate amount of blood". At 12:41 A.M., a health status note indicated resident will be returning to facility by family transport. She received 7 sutures to forehead laceration. A post fall risk evaluation indicated resident was high risk for falls. A 72 hour post fall document indicated there was an ordered alarm present, but was not attached to resident at time of fall. Immediate intervention was to make sure alarm was in place and functioning and resident was immediately sent to ED (Emergency Department) for evaluation. The order for the alarm and the care plan were not updated and a new intervention was not put into place after the fall.		sheets will be updated following any resident fall. *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 nursing staff on the facility's fall prevention program. The staff has been re-educated on their individual responsibilities to ensure residents' safety is maintained and that all individualized safety interventions are in place as outlined in the residents' fall prevention care plans. Nursing administration has also been in-serviced on their responsibility to ensure the CNA assignment sheets reflect each residents' current safety interventions. *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 resident's safety. The QA tool will monitor to ensure that all safety interventions are care planned and in place and functioning properly in an attempt to ensure the resident's safety. The tool will also monitor to ensure that the care plan is updated promptly following each fall to reflect any new interventions that have been added and that the CNA assignment sheet has been updated to reflect any changes in the resident's safety	

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	10/10/2024

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

(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
	On 10/3/24 at 11:40 A.M., a current CNA Assignment Sheet, updated 9/27/24, was provided by LPN (Licensed Practical Nurse) 80 and lacked fall prevention measures for Resident 15. During an interview on 10/9/24 at 9:31 A.M., the MDS Coordinator indicated when there was a fall, it was brought up in the morning meeting the next day, or if weekend on Monday for the team to review. The care plans should be revised by the IDT (interdisciplinary team) during morning meeting. She was not sure why the orders were not put in for the alarms and the care plan was not updated sooner then August of 2024 but because of this, the MDS Assessment did not indicate alarm use by the resident accurately. At that time, the DON (Director of Nursing) indicated the floor nurse should immediately assess the resident, do a fall risk assessment, and start documenting on the 72 hour fall follow up document in the clinical record. An immediate intervention would be documented on that and after the IDT team met the next morning they may add to or discontinue that order which would be reflected in the resident's falls care plan. She was unsure why the orders were not in place and the care plan was not updated until August of 2024. On 10/9/24 at 2:12 P.M., a current Fall Prevention Policy, dated 4/13/22, was provided by the DON and indicated " ... Purpose: to establish a facility wide fall program to identify, evaluate, and provide supervision and assistive devices as appropriate for each resident to prevent falls and fall related injuries ... identify risk factors associated with each resident and develop an individualized plan of care that mitigates or remove those risks ... to establish a method for communicating interventions to staff to prevent falls and reduce fall related injuries ... Procedure: ...		interventions. 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.	

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	10/10/2024

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

(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
	If a fall should occur, a fall huddle will start immediately involving all available witnesses. These huddles should only take 5-10 minutes and a new intervention will be put into place. Root cause analysis form (5 why's) will be used to determine the cause of the fall and the care plan will be revised based on root cause determination and new intervention ... New interventions will be placed on the CNA assignment sheets ... " 3.1-45(a)(2)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation and interview, the facility failed to post the nurse staffing data sheet on a daily basis at the beginning of each shift for 2 of 5 days (10/3/24, 10/7/24) reviewed for posted nurse staffing data sheet posting. (Main Building and Daisy House) Findings include: On 10/3/24 at 11:30 A.M., the posted nurse staffing data sheet in the main building was observed with the date of 10/2/24. On 10/3/24 at 11:34 A.M., the posted nurse staffing data sheet in the Daisy House was observed with the date of 10/2/24. On 10/7/24 at 8:30 A.M., the posted nurse staffing data sheet in the main building was observed with the date of 10/6/24. During an interview on 10/9/24 at 9:34 A.M., the DON (Director of Nursing) indicated night shift should post the nurse staffing data sheet daily by the beginning of the morning shift at 6:00 A.M.	F 0732	F – 732 *The corrective action taken for those residents found to have been 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 this deficient practice. The night shift nurse is now posting the daily staffing data sheet prior to the end of their shift daily. *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. The night shift nurse is now posting the daily staffing data sheet prior to the end of their shift daily. *The measures that have been put into place to ensure that the deficient practice does not recur is*	11/19/2024

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	10/10/2024

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

(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
	On 10/9/24 at 2:12 P.M., a current non dated Posting Direct Care Daily Staffing Numbers Policy, was provided by the DON and indicated " ... Within two (2) hours of the beginning of each shift, the number ... directly responsible for resident care is posted ... "		*that* a mandatory in-service has been conducted for the night shift nursing staff on their responsibility to ensure that the daily staffing data sheet is posted prior to the end of their shift each day. *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 for compliance. This tool will monitor to ensure that the daily staffing data sheet is posted at the end of the night shift daily by the night nurse on duty. 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.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on observation, interview, and record review, the facility failed to ensure residents receiving psychotropic medications were assessed for continued use of the medication for 1 of 5 residents reviewed for unnecessary medications. A resident's antipsychotic medication was not decreased timely as recommended, and was increased with no indication. (Resident 15)	F 0758	F - 758 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 15 has been reviewed by the interdisciplinary team related to behavior tracking and the use of psychotropic medications. The resident's	11/19/2024

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	10/10/2024

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

(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
	Findings include: On 10/3/24 at 2:40 P.M., Resident 15 was observed sitting in a recliner with her eyes closed. On 10/9/24 at 9:00 A.M., Resident 15's clinical record was reviewed. Diagnosis included, but were not limited to, dementia with behaviors, anxiety, and depression. The most recent Annual MDS (Minimum Data Set) Assessment, dated 7/18/24, indicated a severe cognitive impairment, and required extensive assistance of two staff with bed mobility, transfers, and toileting. Resident 15 was currently taking an antipsychotic with the most recent GDR (Gradual Dose Reduction) on 1/5/24. Current physician orders included, but were not limited to: olanzapine (Zyprexa) (an antipsychotic) 10mg (milligrams) one time a day related to vascular dementia with psychotic disturbance and depression, dated 10/9/24. Monitor for behaviors of itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, or refusing care. Document "Y" if monitored and none of the above observed. "N" if monitored any of the above was observed, select chart code other/see nurses notes and progress note findings every day and night shift for nursing measure, dated 7/12/22. Other physician orders included, but were not limited to:		behaviors are being monitored each shift and documented in accordance with facility policy. The consultant pharmacist is continuing to monitor the use of psychotropic medications in accordance with the regulations and will make recommendations as warranted related to medication reduction. These recommendations will be promptly forwarded to the physician for their response and documented in the clinical record. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents who are receiving psychotropic medications have the potential to be affected by this deficient practice. A housewide audit of all residents receiving psychotropic medications has now been conducted by the interdisciplinary team to ensure that behaviors are being tracked and documented in the clinical record in accordance with facility policy. In addition, the consultant pharmacist is continuing to review those residents on psychotropic medications in accordance with the regulation and make necessary recommendations as warranted. All recommendations for dose reductions are promptly forwarded to the physician for their response and documented in the clinical record.	

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	10/10/2024

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

(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
	olanzapine 5mg at bedtime related to depression, anxiety, and vascular dementia, dated 1/5/24 and discontinued 10/8/24. olanzapine 7.5mg at bedtime related to depression, anxiety, and vascular dementia with psychotic disturbance, dated 8/9/23 and discontinued 1/5/24. A current care plan, revised 9/1/23, indicated Resident 15 took a routine antipsychotic medication as behavioral management related to a diagnosis of depression, anxiety, and dementia with psychotic disturbances. Interventions included, but were not limited to: IDT (Interdisciplinary Team), pharmacy, and my physician to consider dosage reduction when clinically appropriate at least quarterly, dated 7/20/22, and monitoring resident and recording occurrence of any behaviors, dated 7/20/22. A Consultant Pharmacist Recommendation to Physician form indicated a pharmacy review had been completed on 12/18/23 with a recommendation to decrease Zyprexa from 7.5mg to 5mg. An agreement from the NP (Nurse Practitioner) was dated 1/5/24 on the same form. A progress note, dated 1/5/24 at 12:16 P.M., indicated Zyprexa was decreased from 7.5mg to 5mg daily at bedtime with approval from the physician as the pharmacy consultant made a federal guideline recommendation. The order was changed (18 days after the pharmacy recommendation) and would be monitored for adverse reactions. A social services note, dated 10/3/24 at 12:55 P.M., indicated a monthly behavior review for the month of September 2024. The resident had two		*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has now been provided for all licensed nurses, social services and QMAs on the facility's behavior management program and their responsibilities related to documenting behaviors and processing all pharmacy drug reduction recommendations in a timely manner. They were also reminded of their responsibility to ensure that the physician's response to those recommendations be recorded in the clinical record and all new orders processed timely. *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 effectiveness of the facility's behavior management program. The tool will monitor to ensure that behaviors have been identified and are being monitored each shift and documented in the clinical record. The tool will also monitor to ensure that all psychotropic medications are being reviewed as required by the regulation for possible drug reduction when warranted. The tool will also monitor to ensure that the physician has been notified of all drug reduction recommendations and has	

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	10/10/2024

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

(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
	behaviors reported during the month of confusion, agitation, and looking for her late husband. The most recent physician visit note in the clinical record, dated 9/4/24, indicated nursing staff noted a significant overall decline in the resident's status in recent months, and to continue current medications including, but not limited to, Zyprexa at 5mg per day. A nursing note, dated 10/8/24 at 12:33 P.M., indicated a new order was given by the physician to increase Zyprexa to 10mg. Resident 15's progress notes included the following behavior notes from September through October 2024: 9/1/24 at 3:23 A.M. Resident woke up with some confusion and agitation. The resident was attempting to get out of bed to find her late husband, as well as seeing kids in the hall. Resident could not be distracted or redirected. Resident requested to call daughter. Staff called and resident spoke with daughter. 9/1/24 at 3:35 A.M. Resident more calm after speaking with daughter. After speaking with the resident, she understood she needed to stay in bed and not attempt to get up without assistance. Resident 15's TAR (Treatment Administration Record) from September through October 2024 indicated a checkmark for day and night shifts for monitoring of behaviors. The TAR did not include a "Y" or "N" to indicate if the resident displayed a behavior or not during the shifts. On 9/25/24 and 9/28/24, behavior monitoring was not marked with anything and left blank on night shift.		responded to the recommendations in a timely manner. 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.	

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	10/10/2024

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

(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
	Resident 15's clinical record lacked any other behavior monitoring documentation. Resident 15's clinical record lacked a rationale for increasing (doubling) the Zyprexa from 5mg to 10mg on 10/8/24. Resident 15's MAR (Medication Administration Record) from October 2024 indicated Zyprexa 5mg had been given daily at bedtime from 10/1/24 through 10/7/24 (the resident's neurologist had ordered to be given at night as it may had contributed to daytime sleepiness). A new order for Zyprexa 10mg daily had been started on 10/9/24 and given at 8:00 A.M. Resident 15 had not been given a dose of Zyprexa on 10/8/24. On 10/9/24 at 10:45 A.M., the DON (Director of Nursing) indicated all behaviors were documented in the progress notes as a behavior note, and were not documented anywhere else in the chart. She indicated the SSD (Social Services Director) would print off the behavior notes to bring daily to the morning meetings to be reviewed. On 10/9/24 at 11:30 A.M., LPN (Licensed Practical Nurse) 28 indicated behavior monitoring in the TAR should not just be checkmarked, and should indicate a "Y" or "N" to indicate if there was a behavior that shift or not. If a behavior was indicated, that specific behavior should be documented in a progress note. On 10/9/24 at 12:10 P.M., the DON (Director of Nursing) indicated all pharmacy recommendations were reviewed the following morning during a morning meeting. If the team decided the recommendation was a good idea, it would be submitted to the physician. She indicated			

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	10/10/2024

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

(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
	Resident 15's physician was coming to the facility about once a month, so pharmacy recommendations were having to be faxed or texted, and the physician was not quick at responding. She indicated after the pharmacy had made a recommendation to decrease Resident's Zyprexa on 12/18/23, a staff member should have followed up with the physician, but that staff member was no longer employed at the facility, and was unsure why it took so long for the order to be put in. The DON indicated physician visits were documented in the clinical record the same day as the visit, and if a medication change was ordered, the physician would tell the nurse and the nurse would put the order in. She indicated if the rationale for changing a dosage of medication was known, it would be entered in the clinical record. All medication changes and new orders were reviewed the following morning at the morning meeting, and if needed, staff would clarify with the physician. She indicated when a dosage is changed, the new order would be put in for the same time of day unless the physician indicated specifically that the new dose needed to be given at a different time. She indicated the TAR should indicate that behaviors were being monitored, and was unable to verbalize why Resident 15's behavior monitoring in the TAR was only checkmarked, and did not indicate a "Y" or "N" as ordered. She indicated any behaviors that were monitored would have a progress note. She further indicated she did not have an answer for why Resident 15 was not given a dose of Zyprexa on 10/8/24, only that's how it was generated in the computer when the new order was put in. She indicated she was unsure if staff should have put the order in differently, and thought it was a missed medication dose. On 10/9/24 at 2:12 P.M., the DON provided a			

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	10/10/2024

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

(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
	current Behavior Monitoring policy, dated 10/2017, that indicated "If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing assessments of changes (positive or negative) in the individual's behavior, mood, and function. Staff will document (progress notes or behavior assessment)" On 10/9/24 at 2:12 P.M., the DON provided a current non-dated Gradual Dose Reduction policy that indicated "An interdisciplinary care plan will be established and include person-centered non-pharmacological interventions ... The nursing staff will initiate a way to monitor behavior(s) for which the antipsychotic medication was originally prescribed" On 10/9/24 at 2:12 P.M., the DON provided a current Psychotropic Medication Change policy, dated 5/4/22, that indicated a "Psychotropic Medication Change" progress note should be put into the resident's clinical record, at at least once per shift for the following 7 days. On 10/9/24 at 2:12 P.M., the DON provided a current Psychotropic Medication Use policy, dated 7/2022, that indicated "When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarify whether ... other causes for symptoms (including symptoms that mimic a psychiatric disorder) have been ruled out ... signs and symptoms are clinically significant enough to warrant medication therapy ... a particular medication is clinically indicated to manage the symptoms or condition ... the actual or intended benefit of the medication is understood by the resident/representative"			

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	10/10/2024

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

(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
	3.1-48(a) 3.1-48(b)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure medications were labeled in accordance with currently accepted professional principles and the expiration date for 3 of 4 medication carts observed for medication storage and medications for multiple residents' morning medication pass were stored in medication cups with their names on them in the top left drawer of the medication cart for 1 of 4 medication carts observed during medication pass. (Medication Cart 3 on East Hall in the main building, Medication Cart in Rose House, Medication Cart in Daisy House) Finding includes: 1. On 10/3/24 at 10:05 A.M., the following was observed in Medication Cart 3 on the East Hall in the main building: Resident 38's Refresh Tears 0.5% Eye drops and Olopatadine 0.1% Eye Drops, no open date Resident 14's Albuterol 90 mcg (microgram) Inhaler did not have an open date and Genteal Eye Drops with an open date of 12/15/23 Resident 40's Ventolin 90 mcg Inhaler, Genteal Eye Drops, and Anoro Elpta 62.5 -25 mg (milligram) Inhaler did not have open dates, and Flutisone 0.05 % Nasal Spray with an open date of 8/10/24 Resident 159's Brea Ellipta 200 mcg/25 mcg Inhaler, Fluticasone 50 mcg Nasal Spray, and Ayr	F 0761	F - 761 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the eye drop medications identified during the survey belonging to the resident identified as resident 38 were immediately discarded and new bottles of eye drops were obtained. The eye drop containers will now be dated when opened. The albuterol inhaler and the Genteal eye drops belonging to the resident identified as resident 14 have been discarded and a new albuterol inhaler and bottle of Genteal eye drops have been obtained for the resident. These medications will be dated when opened. The Ventolin inhaler, Genteal eye drops and the Flutisone nasal spray belonging to the resident identified as resident 40 were immediately discarded and a new inhaler along with eye drops and nasal spray were obtained for the resident. These new items will be dated when opened. The nasal sprays, nasal gel and the two inhalers belonging to the resident identified as resident 159 were immediately	11/19/2024

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	10/10/2024

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

(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
	Nasal Gel, and Afrin 0.05% Nasal Spray did not have open dates, and Symbicort 160/4.5 mcg Inhaler with an open date 8/18/24 Resident 20's Flonase 50 mcg Nasal Spray, no open date Resident 160's Xalatan 0.05% Eye Drops, no open date Resident 4's Visine Dry Eye Relief, no open date Resident 17's Latanoprost 0.005% Eye drops and Sucralfate 1 gm (gram) Syrup, no open date 2. During an observation of medication pass on 10/7/24 at 7:25 A.M., RN (Registered Nurse) 5 opened the top left drawer of the Medication Cart 3 on the East Hall and retrieved Resident 13's medication cup. At that time, it was observed there were 3 other medication cups with pills in them and resident names on the cups. 3. On 10/3/24 at 10:52 A.M., the following was observed in the Medication Cart for the Rose House: Resident 28's Levimir 100 u/ml (units per milliliter) Insulin and Flonase 0.05 % Nasal spray did not have open dates, and Proair 90 mcg Inhaler, with an open date of 5/12/24 Resident 37's Flonase 0.05 % Nasal Spray with an open date of 8/27/24 Resident 45's Flonase 0.05% Nasal Spray, Combigan 0.2/0.5% Eye Drops, Systane 0.3-0.4% Eye Drops, and Saline Mist 0.65% Nasal Spray, no open dates Resident 47's Flonase 0.05% Nasal Spray, no open		discarded and new supply of these items were obtained. The medications will now be dated when opened. The Flonase Nasal spray belonging to the resident identified as resident 20 was immediately discarded. No new nasal spray was ordered since the medication was no longer ordered for this resident. The Xalatan eye drops belonging to the resident identified as resident 160 were immediately discarded and a new bottle of eye drops was obtained and is now dated with the date opened. The Visine eye drops belong to the resident identified as resident 4 were immediately discarded and a new bottle of Visine eye drops has been obtained and will be dated when opened. The Latanaprost eye drops and the Sucralfate syrup belonging to the resident identified as resident 17 were immediately discarded and new containers of those medications have been obtained and were dated when opened. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 13 is now receiving their medications that have been prepared immediately prior to administration of those medications and not pre-set. The nurse identified as RN 5 has been re-educated on the facility's	

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	10/10/2024

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

(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
	date 4. On 10/3/24 at 11:00 A.M., the following was observed in the Medication Cart for the Daisy House: Resident 31's Prostat, Artificial Tears Eye Drops, Lubricating Ophthalmic Oint, Stye lubricant Eye Ointment, no open dates Resident 42's Fluticasone propionate/salmeterol 250/50 mcg Inhaler and Albuterol HFA (hydrofluoroalkane) inhaler, no open dates Resident 23's Flonase 0.05% Nasal Spray and Deep Sea 0.65% Nasal Spray, no open dates Resident 19's Fluticasone 50 mcg Nasal Spray, no open date A resident's Flonase 0.05% Nasal Spray, no open date During an interview on 10/3/24 at 10:05 A.M., LPN (Licensed Practical Nurse) 42 indicated there should be an open date on all eye drops, inhalers, and insulin. She indicated medications, once opened, were good for 30 days. During an interview on 10/7/24 at 7:31 A.M., RN 5 indicated first thing when she started her shifts, she got the medications ready for the residents' morning medication pass. During an interview on 10/9/24 at 9:34 A.M., the DON (Director of Nursing) indicated medications should not be pre-set and placed in cups, or setup for the day, medications should be labeled when opened, and should be used in so many days but she was not sure how long.		medication administration policy. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the Levimir insulin, Flonase spray and Proair inhaler belonging to the resident identified as resident 28 were immediately discarded and new medications have been obtained to replace them. These medications were each dated when opened. The Flonase nasal spray belonging to the resident identified as resident 37 was immediately discarded and a new container of Flonase has been obtained and will be dated when opened. The Flonase nasal spray, Combigan eye drops, Systane eye drops and Saline nasal spray belonging to the resident identified as resident 45 were immediately discarded and new medications to replace these items have been obtained and dated when opened. The resident identified as resident 47 is no longer a resident at the facility. F – 761 continued *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the Prostat, Artificial tears, Lubricating Opth. Ointment and Stye Lubricant eye ointment belonging to the resident identified as resident 31 were immediately discarded and a new supply of these medications were	

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	10/10/2024

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

(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
	On 10/9/24 at 9:50 A.M., a current Medication Expiration Date Policy, dated October 2020, was provided by the DON and indicated " ... Levimir: 42 days refrigerated or at room temp ... Advair [Fluticasone propionate/salmeterol] Inhaler:30 days after removal from foil pouch ... Breo Inhaler: 6 weeks after opening ... Albuterol /Ventolin Inhalers: 6 weeks after opening ... Symbicort Inhaler: 3 months after removal from foil pouch ... " On 10/9/24 at 2:12 P.M., a Medication Storage Policy, dated 5/21/18, was provided by the DON and indicated " Medication storage area conditions are monitored on a monthly basis and corrective action taken if problems identified ... some medications have shortened expiration dates ... Medication(s) prepared for one person at a time ... Medication(s) are administered at time they are prepared ... Do not pre-pour or pre-set medication(s) ... " On 10/9/24 at 2:12 P.M., a Medication Administration Policy, dated 5/21/18, was provided by the DON and indicated " ... Be sure to read labels at least three (3) times ... check expiration dates of medication(s) to be administered ... " 3.1-25(b)(5) 3.1-25(j)		obtained and have been dated when opened. The Fluticasone propionate/salmeterol inhaler and albuterol inhaler belonging to the resident identified as resident 42 were immediately discarded and new inhalers have been obtained and dated when opened. The Flonase and Deep Sea nasal spray belonging to the resident identified as resident 23 was immediately discarded and a new supply of these medications has been obtained for the resident and dated when opened. The Flonase nasal spray belonging to the resident identified as resident 19 was immediately discarded and a new container of Flonase nasal spray has been obtained and dated when opened. *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. All residents are now receiving their medications that have been prepared by the nurse and/or QMA immediately prior to the administration of those medications. No pre-set of medications is permitted per facility policy. A housewide audit of all medication carts has now been conducted to ensure that all required medications have been dated when opened and that any medications that are past their	

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	10/10/2024

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

(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
			expiration date are immediately pulled from the med cart for reorder. All medications on the med carts now contain an open date when required and no medications are left on the cart beyond their expiration dates. *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 and QMAs on the facility's medication administration policies. All staff members were instructed on the facility policy related to medication preparation (no pre-set medications) as well as the required dating of medications when opened. The staff was reminded that it is their responsibility to pull any expired/outdated medications and order new supplies as needed. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implement to monitor medication administration and medication storage to ensure that all required medications are properly dated when opened and if the medication is expired/outdated that it is immediately pulled from the med cart and reordered. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and	

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	10/10/2024

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

(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
			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.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on interview, observation, and record review, the facility failed to ensure food was stored and prepared safely in accordance with professional standards for food service for 2 of 2 kitchen observations. Foods were not labeled correctly and a used cooking utensil was dropped into the food to be served. Temperature and dishwasher logs were not filled out daily. (Daisy House, Rose House) Findings include: 1. On 10/3/24 at 10:26 A.M., the following was observed in the Daisy House kitchen refrigerators: tomatoes in a Tupperware bowl-- undated and unlabeled 112 oz (ounce) can of milk chocolate pudding-- undated, unlabeled, and open to air 2. On 10/3/24 at 10:26 A.M., the following was observed in the Daisy House kitchen freezers: chicken patty's-- undated and unlabeled diced chicken-- undated and unlabeled 3 clear glasses's with a frozen brown substance-- undated and unlabeled 2 bags of biscuits-- undated and unlabeled bag of vegetables-- undated and unlabeled [name of company] cup with brown substance-- undated and unlabeled hash browns-- undated, unlabeled, and open to air	F 0812	F - 812 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The tomatoes and milk chocolate pudding identified in the refrigerator in the Daisy House during survey were discarded. All items currently in the refrigerator in the Daisy House are now properly covered, labeled and dated. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. All of the food items that were unlabeled, undated and not properly covered in the Daisy House freezer during the survey have been discarded. All items	11/19/2024

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	10/10/2024

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

(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
	3 cooked eggs-- undated and unlabeled cauliflower florets-- undated and unlabeled 9.5 brown squares-- undated and unlabeled 4 hot dogs-- undated, unlabeled, and open to air 3. On 10/8/24 at 9:45 A.M., the temperature logs were reviewed at the Daisy House and lacked a temperature recorded for the refrigerator/freezers, 2 door freezer, stock fridge, stock freezer, and the dish machine on the following dates from August through October: August 1--7 August 9--11 August 14--18 August 20 August 23 August 28 August 31 September 1 September 3 September 6 September 10--11 September 14--15 September 17 September 20 September 23--24 September 26 September 28--29 September 31 October 3--4 October 7 4. On 10/8/24 at 9:45 A.M., the temperature logs were reviewed at the Rose House and lacked a temperature recorded for the refrigerator/freezers, 2 door freezer, stock fridge, stock freezer, and the dish machine on the following dates from August through October: August 12--13 August 19		currently in the freezer have now been properly covered, labeled and dated. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents staff and visitors have the potential to be affected by this deficient practice. Temperature logs are now being maintained daily for the refrigerator/freezer, two door freezer, stock refrigerator/freezer and the dish machine in the Daisy House. Daily temperatures are being recorded on each of the designated temp log for each appliance. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents staff and visitors have the potential to be affected by this deficient practice. Temperature logs are now being maintained daily for the refrigerator/freezer, two door freezer, stock refrigerator/freezer and the dish machine in the Rose House. Daily temperatures are being recorded on each of the designated temp log for each appliance. *The corrective action taken for the other residents that have the potential to be affected by the*	

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	10/10/2024

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

(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
	August 21--22 August 24--26 August 29--30 September 2 September 4--5 September 7--9 September 12--13 September 16 September 18--19 September 21--22 September 26--27 September 30--31 During an interview on 10/8/24 at 10:23 A.M., the Dietary Manager indicated food should labeled with the item and dated and food should not be stored open to air. At that time, she indicated the temperature logs for the refrigerators, freezers, and dish washers should be filled out daily. On 10/3/24 at 1:22 P.M., the Dietary Manager provided a current, undated To provide proper storage of food policy that indicated, "...All opened food that is refrigerated will be labeled with contents, date prepared and used within 3 days or discarded. Items placed in the freezer will be labeled with contents, dated and used within six months..." On 10/9/24 at 2:12 P.M., the DON (Director of Nursing) provided a current, undated To ensure food is kept at proper temperature policy that indicated, "The dayshift cook will take temperatures of all refrigerators and freezers and record on temperature log..." On 10/10/24 at 10:48 A.M., the Dietary Manager provided a current, undated To ensure that dished are sanitized properly policy that indicated, "Dish machine will be started, and temperature of rinse		*same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All food and beverage items are now being properly covered labeled and dated. Any outdated food items are immediately removed and discarded. Temperature logs are now being maintained daily by staff on each food storage and cleaning appliance. (All refrigerators, freezers, and dish machines.) *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has now been provided for all staff assigned to the Rose House and Daisy house on food safety. The staff has been re-educated on proper food storage to ensure all items are covered properly, labeled and dated and any expired food/beverage items are promptly removed from usage when outdated. The staff was also re-educated on their responsibility to check and record refrigerator/freezer and dish machine temperatures daily as well as to immediately report any temperatures that do not meet the food safety requirements. F – 812 continued *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been	

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	10/10/2024

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

(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
	water will be recorded on a temperature log daily by dietary personnel..." 3.1-21(i)(2) 3.1-21(i)(3)		developed and implemented to monitor food safety. This tool will monitor to ensure that all food and beverage items are properly covered, labeled and dated. The tool will also monitor to ensure that daily temperatures are recorded on all food storage appliances such as refrigerators and freezers as well as daily temperatures recorded for the dish machine. This tool will be completed by the Food Service Manager 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.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to ensure a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Staff did not change gloves or perform hand hygiene during resident care for 1 of 2 residents observed for care. A medication was touched with bare hands for 1 of 8 observations of medication administration, and staff did not perform hand hygiene before or after administering medications. (Resident 39, Resident 22) Findings include:	F 0880	F – 880 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 39 is now receiving personal care by staff members who are performing correct hand hygiene and glove usage during personal care in accordance with acceptable standards of infection control practices. QMA 15 and CNA 34 have been re-educated on hand	11/19/2024

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	10/10/2024

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

(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
	1. On 10/9/24 at 9:35 A.M., QMA (Qualified Medication Aide) 15 and CNA (Certified Nurse Aide) 34 performed incontinence care on Resident 39. QMA 15 wiped Resident 39's perineal area and buttocks and then failed to change gloves and perform hand hygiene before the clean brief was placed under Resident 39 by QMA 15. Then, QMA 15 and CNA 34 removed gloves and pulled up Resident 39's brief, placed the lift pad under the resident, and then QMA 15 touched the lift with her hands to move it. At that time, QMA 15 went in the restroom to perform hand hygiene. During an interview on 10/9/24 at 10:50 A.M., the Infection Preventionist indicated staff should change gloves and perform hand hygiene between dirty and clean tasks, and items should not be touched with soiled hands after care is performed. 2. During an observation of medication pass on 10/07/24 at 8:19 A.M., LPN (Licensed Practical Nurse) 36 was preparing medications for Resident 42. Dicyclomine 20 mg (milligram) was in a bottle from home. LPN 36 dumped pills from the bottle into the medication cup containing 2 other medications. Two pills went into the cup. She took 1 pill out with her bare hand, put it back into the medication bottle, proceeded to finish putting the other medications into the medication cup, and administer them to the resident. LPN 36 did not sanitize her hands before or after prepping or administering the medications. During an interview on 10/9/24 at 9:34 A.M., the DON (Director of Nursing) indicated staff should sanitize hands in between residents when passing meds and should not touch pills with bare hands. On 10/9/24 at 2:12 P.M., the DON provided a current Briefs/Underpads Policy, revised January		hygiene and glove usage. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 42 is now receiving their medications by staff members who are following acceptable standards of medication administration and infection control practices. LPN 36 has been re-educated on the facility's policies related to medication administration and infection control practices during the administration of medication. *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. All residents are now receiving personal care and medication administration by staff members that are adhering to the facility's policies on infection control practices for personal care and medication administration. *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 nursing staff on the facilities policies related to infection control practices for personal care and medication administration. All staff members were re-educated on hand hygiene and proper glove usage.	

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	10/10/2024

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

(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
	2024, that indicated, "Roll the brief from the bottom toward the resident...Remove gloves, sanitize hands and replace gloves..." On 10/9/24 at 2:12 P.M., the DON provided a current Handwashing/Hand Hygiene policy, revised October 2023, that indicated, "...Hand Hygiene is indicated:...after contact with blood, body fluids...after touching a resident..." On 10/9/24 at 2:12 P.M., a current Medication Administration Policy, dated 5/21/18, was provided by the DON and indicated " ... Hand hygiene is completed before and after every medication preparation or administration ... wear disposable gloves if need to touch tablets ... " 3.1-18(l)		*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 facility's infection control practices, with a focus on hand hygiene and glove usage during personal care as well as proper infection control practices during the administration of medication. This tool will be completed by the Infection Control Preventionist 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.	
F 9999 Bldg. 00	3.1-4 Notice of rights and services (f) The facility must do the following: (11) If the facility is required to submit an Alzheimer's and dementia special care unit disclosure form under IC 12-10-5.5, provide the resident at the time of admission to the facility with a copy of the completed Alzheimer's and dementia special care unit disclosure form. 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	F 9999	9999 *The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey however every resident residing in the Daisy House has the potential to be affected by this deficient practice. The facility has now submitted an Alzheimer's Dementia Special Care Unit disclosure to the state survey agency for the Daisy House.	11/19/2024

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	10/10/2024

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

(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
	Care Unit disclosure was submitted to the state survey agency after a new building that housed Dementia residents was opened. (Daisy House) Findings include: On 10/3/24 at 1:12 P.M., the Administrator provided a Dementia Disclosure for the Rose House. At that time, he indicated a Dementia Disclosure had not been completed for the Daisy House when it opened. During an interview on 10/9/24 at 10:42 A.M., the DON (Director of Nursing) indicated on 5/29/24 the first resident moved into the Daisy House. On 10/10/24 at 10:49 A.M., the Administrator indicated they do not have a policy related to the Dementia Disclosure, but they would follow the state regulation.		*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents of the Daisy House have the potential to be affected by this deficient practice. The facility has now submitted an Alzheimer's Dementia Special Care Unit disclosure to the state survey agency for the Daisy House. *The measures that have been put into place to ensure that the deficient practice does not recur is that* the facility Administration has now been educated on the requirements of submitting a disclosure to the state survey agency when any additional houses are constructed for the purpose of caring for those residents with dementia. The appropriate disclosure forms will be submitted to the state when any additional structures are added to the facility. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* this subject will be reviewed annually at the facility's Quality Assurance meetings to determine if any additional structures will be added which require this disclosure to be provided to the state survey agency. Disclosures will be submitted as required.	