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	02/26/2025

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 the Investigation of Complaints IN00453338 and IN00452372. Complaint IN00453338: Federal/State deficiencies related to the allegation(s) are cited at F689. Complaint IN00452372: No deficiencies related to the allegation(s) are cited. Survey date: February 26, 2025 Facility number: 000300 Provider number: 155539 AIM number: 100287340 Census Bed Type: SNF: 3 SNF/NF: 60 Total: 63 Census Payor Type: Medicare: 4 Medicaid: 44 Other: 15 Total: 63 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 4, 2025	F 0000		
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to prevent falls for 2 of 3 residents reviewed for accidents. Following falls,	F 0689	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We	03/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Millikan	Administrator	03/21/2025

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	02/26/2025

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 care plans were not updated with interventions to prevent further falls, and a resident's environment was not free of hazards, which resulted in a fall and leg fracture. (Resident C, Resident D) Findings include: 1. Record review for Resident C was completed on 2/26/25 at 11:15 A.M., Resident C's diagnoses included, but were not limited to, fracture of lower end right femur, cellulitis of left lower limb, type II diabetes, morbid obesity, muscle weakness, need for assistance with personal care, and overactive bladder. Resident C's most recent Significant Change Minimal Data Set (MDS) assessment, dated 2/3/25, indicated the resident had no cognitive impairment, required substantial/maximal assistance with bathing (helper does more than half the effort), required supervision with transfers, had an indwelling catheter, and had no falls since the previous quarterly MDS assessment, dated 11/3/24. Resident C's care plan included, but was not limited to, resident needed help with transfers, walking, and locomotion on/off unit due to diagnoses (revised 5/13/24) and resident was at risk for falls and fall-related injury due to dependence on staff for activities of daily living (ADLs), and diagnoses. The resident's most recent fall score of 6 and most recent fall was on 9/1/23, with minor injury (revised on 11/1/24). A fall intervention included, "before leaving my room, monitor that my environment is safe: floors free from spills..." (revised 8/5/24). The care plan was last reviewed and continued with previous interventions on 11/1/24.		reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective March 21, 2025 to the state findings of the Complaint Survey conducted on February 26, 2025. F – 689 *1. The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C is now receiving care and services in an effort to prevent future falls, including ensuring that the floor surface is clean and completely dry prior to all transfers/ambulation. The CNA identified as CNA 6 is no longer employed by the facility. The resident's care plan has now been updated to reflect all fall risk interventions currently utilized for this resident. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D has been reviewed by the interdisciplinary team related to fall risks. The resident's fall risk care plan has now been updated to include additional interventions in an effort to prevent future falls. 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	02/26/2025

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
	An Indiana Department of Health (IDOH) Facility Reportable Incident (FRI) form, dated 02/08/25 at 12:05 P.M., indicated Resident C slipped in urine on the floor while the CNA tried to assist the resident out of a chair and to the shower. Resident C's progress notes included, but were not limited to: 2/8/25 at 12:58 P.M. - At approximately 12:25 P.M., CNA 6 yelled for help because the resident had fallen to the floor. LPN 2 entered the room to find the resident lying on the floor with the right leg angled outward in an unnatural position. Resident C yelled in pain. CNA 6 indicated that the resident's catheter bag had leaked on the floor and resident slipped while being transferred to the shower. The resident left the facility with Emergency Medical Services (EMS) at 12:41 P.M. 2/9/25 at 8:52 A.M. - The nursing staff called the hospital for an update on the resident. The hospital nurse indicated the resident was having surgical repair of the fractured right femur. 2/20/25 at 10:42 A.M. - Social service note - A social service staff member visited with the resident to see how he was doing since returning from the hospital on 2/18/25. The resident was lying in bed, which was not his norm prior to the hospital stay. During an observation and interview on 2/26/25 at 1:45 P.M., Resident C was lying in bed with a cover pulled over his body. Resident C indicated that he had fallen in his room after his catheter bag had leaked, which resulted in a fractured right leg. The resident indicated at the time of his fall; a CNA was about to give him a shower, but his catheter bag had leaked onto the room floor. The CNA wiped the floor with towels, but the floor was not completely dry. Resident C told the CNA		resident has not had any additional falls at the time of this writing. *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 fall risk care plans has now been completed to ensure that each resident has the appropriate safety interventions in place in an effort to prevent future falls. *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 nursing staff on the facility's fall prevention program. Each staff member was reminded of their responsibilities related to resident safety and to ensure that all safety interventions are consistently in place for each resident in an effort to prevent future falls. *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 prevent future falls. The tool will monitor to ensure that fall risk assessments are routinely completed for each resident and updated following each fall in an	

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	02/26/2025

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
	the floor was still wet, but the CNA insisted it was dry and indicated the resident could get up for a shower. Resident C then stood, slipped, and fell to the floor. Resident C indicated the CNA appeared to be in a hurry. A review on 2/26/25 at 2:15 P.M., a facility investigation of Resident C's fall on 2/8/25 included a handwritten description of the fall by CNA 6, dated 2/9/25. The description indicated that Resident C had requested a shower. As CNA 6 walked to Resident C's room, the housekeeper stopped to notify her that Resident C's catheter bag had leaked and needed to be cleaned up. CNA 6 cleaned "the mess." Resident C stated the staff had not closed his catheter bag completely. CNA 6 placed Resident C's walker in front of him as he raised his chair to stand. The resident's walker had the catheter bag clipped to the right side. CNA 6 had turned around to open the shower room door, and then turned back around to observe Resident C had stood and his "right leg went from underneath him. [Resident C] fell back, landed on the chair (and) slid down chair to floor." CNA 6 notified the nurse of the fall and then observed Resident C's catheter bag clamp was not close. CNA 6 notified (LPN 2) that the catheter bag had leaked. During an interview on 2/26/25 at 2:30 P.M., LPN 2 indicated she was Resident C's nurse on 2/8/25. LPN 2 indicated at that time; Resident C needed assistance with transfers following an overall decline. Following Resident C's fall on 2/8/25, LPN 2 entered the resident's room, knelt to assess the resident, and noticed urine on the floor. During an interview on 2/6/25 at 2:50 P.M., the Facility Administrator indicated CNA 6 had not completely closed Resident C's catheter drain. The		effort to identify all fall risk factors and that the resident's care plan clearly reflects all fall risk safety interventions and that those interventions are in place. 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	02/26/2025

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
	CNA later returned to the resident's room to clean the urine from the floor, but did not clean the floor properly. The Facility Administrator indicated CNA 6 should have known to clean the floor with a mop but instead used towels to dry the urine. 2. During record review on 2/26/25 at 11:3 A.M. D's diagnoses included, but were not limited to, urgency of urination, unsteadiness on feet, anxiety, vascular dementia, explosive disorder, cerebral palsy, muscle weakness, history of falling, and repeated falls. Resident D's most recent quarterly MDS assessment, dated 12/1/24, indicated the resident had moderate cognitive impairment and had two or more falls since the previous assessment. Resident D's care plan included, but was not limited to, resident needs help with transfers, walking, and locomotion due to diagnoses (revised 7/11/24) with an intervention, resident requires assist of one staff and use of rolling walker for transfers and walking (12/5/24). Resident at risk for falls and fall-related injury due to diagnoses and easily distracted, resists calling for assistance with transfers (revised 2/19/25) Last fall: 2/14/25. Fall interventions indicated the resident's daily routine had been monitored and the history of falling had no noted patterns other than the resident did not call for assistance with transfers. Perform frequent checks on the resident to watch for attempts to rise unassisted and promptly offer assistance when observed (initiated 2/3/25). Staff verbally remind resident to call for assistance before transfer, and staff promptly respond to all requests for assistance. Staff have put a sign in the resident's room as a reminder of this. (revised 2/3/25)			

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	02/26/2025

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 D's progress notes included, but were not limited to: 1/22/25 at 6:00 P.M. - Resident yelled for help from his room at this time. The nurse entered the room and found the resident on his knees in front of his recliner. 1/25/25 at 4:06 P.M. - Staff found the resident sitting in front of wheelchair beside bed on floor. 1/28/25 at 11:34 P.M. - CNA entered the resident room to find resident on knees in between wheelchair and bed holding onto the side rail of the bed. 2/14/25 at 10:30 P.M. - CNA reported resident was on the floor at 6:20 P.M. Resident had just been assisted to recliner. During an interview on 2/26/25 at 1:50 P.M., LPN 9 indicated Resident D often fell near his recliner in his room. The resident often refused to call for assistance or would try to transfer himself just after receiving assistance. LPN 9 indicated the resident was unable to walk and required the assistance of one staff member and the use of his walker for transfers. LPN 9 indicated that following the resident falls, staff should try to implement a new intervention to prevent a further fall. During an interview on 2/6/25 at 2:50 P.M., the Facility Administrator indicated that not all care plans had been updated following resident falls. On 2/26/25 at 2:35 P.M., the Admission Coordinator supplied a facility policy titled, Fall Preventions Policy, dated 4/13/22. The policy indicated, "Process: To identify risk factors associated with each resident and develop an individualized plan of care that mitigates or removes those risks... Procedure: ...4. If a fall should occur... a new appropriate intervention will			

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	02/26/2025

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
	be put into place... the care plan will be revised based on ... new intervention." This citation relates to complaint IN00453338. 3.1-45(a)(1)			