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	04/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00405347. IN00405347: Federal/State deficiencies related to the allegations are cited at F600 and F609. Survey date: April 10, 2023 Facility number: 000300 Provider number: 155539 AIM number: 100287340 Census Bed Type: SNF: 5 SNF/NF: 52 Total: 57 Census Payor Type: Medicare: 9 Medicaid: 35 Other: 13 Total: 57 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 13, 2023.	F 0000	April 21, 2023 Brenda Buroker Director Division of Long-Term Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Bertha D. Garten Ketcham Memorial Center Complaint Survey Survey Event ID YXJ411 Dear Ms. Buroker. On April 10, 2023, a Complaint Survey was conducted at our facility. By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective April 21, 2023, to the State findings of the Complaint Survey conducted on April 10, 2023. ="" span="">	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Wittmer	Administrator	04/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			We respectfully request a desk review to validate the facility's compliance to the findings of the Complaint Survey conducted on April 10, 2023. Please feel free to contact the facility if any additional information or documents are needed. . Respectfully submitted, /p> Kathy Wittmer, HFA Bertha D Garten Ketcham Memorial Center	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record	F 0600	By submitting the enclosed	04/24/2023

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	review, the facility failed to ensure residents were free from abuse for 1 of 3 residents reviewed for abuse. Staff "flung" hand sanitizer gel over a resident and treated him roughly during care. (Resident D) Finding includes: During a review of State reportable incidents on 4/10/23 at 10:30 A.M., an incident report indicated that there was an allegation from Resident D that staff had beat him up on 3/20/23. CNA 13 and CNA 15 were questioned about the incident and an investigation took place that same day. During record review on 4/10/23 at 10:45 A.M., Resident D's diagnoses included, but were not limited to; history of traumatic brain injury, hemiplegia affecting right dominant side, anxiety, and major depressive disorder. Resident D's most recent annual MDS (Minimal Data Set), dated 2/5/23, indicated the resident's cognition was severely impaired, the resident required extensive assistance with bed mobility, and was totally dependent when transferring. During an observation on 4/10/23 at 12:45 P.M., Resident D was observed in a wheelchair in front of the East hall nurse's station, along with other residents. Resident D refereed to two staff members as "Grandma" as they passed by. During an interview on 4/10/23 at 11:00 A.M., LPN 4 indicated that CNA 13 was terminated from employment for being verbally abusive towards Resident D. During an interview on 4/10/23 at 11:30 A.M., CNA 6 indicated they were in the room during an		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 requests the plan of correction be considered our allegation of compliance effective April 21, 2023 to the state findings of the Complaint survey conducted on April 10, 2023. F - 600 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D is now receiving care and services free of abuse or neglect by any staff members. Resident D has suffered no physical or psychosocial negative outcome from the event. Staff members identified as CNA 13 and CNA 15 were interviewed as part of the investigation and are no longer employed by the facility. The staff member identified as CNA 6 has received a disciplinary action related to failure to report the allegation of abuse immediately to the administrator. *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	

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	incident on 3/20/23 and witnessed an altercation between Resident D and CNA 13. CNA 6 indicated that Resident D often became agitated with staff during care and would call staff inappropriate names. CNA 6 indicated that CNA 13 "flung" sanitizer gel over the resident, landing on his shirt and arms. CNA 13 then "egged him on" as he became more agitated. CNA 13 handled Resident D roughly during care. CNA 6 indicated they had just started working at the facility and didn't know what to make of CNA 13's behavior towards the resident, but did feel as if it was abusive. CNA 6 left for the day, then came forward with the observations the next time they were scheduled to work and alerted the Facility Administrator to what they had witnessed. On 4/10/23 at 1:15 P.M., the Facility Administrator supplied a reportable incident, dated 3/23/23, regarding an abuse allegation involving Resident D and CNA 13. The reportable incident indicated CNA 13 was terminated from employment following another staff member, CNA 6, indicating they had witnessed an incident between Resident D and CNA 13. An undated written statement by CNA 6 included, CNA 13 and I (CNA 6) went in to Resident D's room to administer care. As we are changing the resident, he began to get agitated... I (CNA 6) had him in the Hoyer lift when Resident D called CNA 13 a name. She got frustrated and mad at him and threw hand sanitizer "holy water" on him. It was all over the resident's hand and shirt. He then began calling her even more names and she kept getting even more mad... CNA 13 is never really nice to Resident D when giving care... CNA 13 was purposely being rough on Resident D when giving care.		affected by this deficient practice. A housewide audit of all alert and oriented residents has been conducted as well as observation of the cognitively impaired residents and found no other allegations or evidence of abuse. *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 conducted for all staff on the facility's abuse policy with a focus on immediate reporting to the administrator of any and all allegations of abuse. In addition, the facility has posted reminders in all employee areas of the facility abuse policy as a reminder of reporting all allegations of abuse immediately to the administrator. *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 abuse policy and to ensure that all allegations of abuse are immediately reported to the administrator. This tool will be completed by Social Services 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	

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	During an interview on at 1:00 P.M., the Facility Administrator indicated that CNA 13 was called into the facility following the statement given by CNA 6. CNA 13 neither denied or admitted to the accusation of abuse, and did not provide a statement as to what occurred between themselves and Resident D. CNA 13 was terminated from employment at that time. On 4/10/23 at 10:20 A.M., the Facility Administrator supplied a facility policy titled, [Facility] Abuse Policy and Procedure, dated 12/30/22. The policy included, "It is the purpose of the [Facility Name] to ensure that all employees, residents, family members, consultants, physicians, and visitors are aware that mistreatment, neglect, abuse, and exploitation of residents, misappropriation of resident property and involuntary seclusion is strictly forbidden by this facility..." This Federal tag relates to complaint allegation IN00405347. 3.1-27(b)		additional action is warranted.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse			

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	or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure staff immediately reported suspected abuse to the administrator for 1 of 1 allegations of abuse reviewed. After witnessing an abusive incident, staff left the facility at the end of their shift, and did not report what they had witnessed until their next scheduled shift. (Resident D) Finding includes: During a review of State reportable incidents on 4/10/23 at 10:30 A.M., an incident report indicated that there was an allegation from Resident D that staff had beat him up on 3/20/23. CNA 13 and CNA 15 were questioned about the incident and an investigation took place that same day. During an interview on 4/10/23 at 11:00 A.M., LPN 4 indicated that CNA 13 was later terminated from employment for being verbally abusive towards	F 0609	F - 609 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D is now receiving care and services free of abuse or neglect by any staff members. Resident D has suffered no physical or psychosocial negative outcome from the event. Staff members identified as CNA 13 and CNA 15 were interviewed as part of the investigation and are no longer employed by the facility. The staff member identified as CNA 6 has received a disciplinary action related to failure to report the allegation of abuse immediately to the administrator.	04/24/2023

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	Resident D. During an interview on 4/10/23 at 11:30 A.M., CNA 6 indicated they were in Resident D's room during an incident on 3/20/23, and witnessed an altercation between Resident D and CNA 13. CNA 6 indicated that Resident D often became agitated with staff during care and would call staff inappropriate names. CNA 6 indicated that CNA 13 "flung" sanitizer gel over the resident, landing on his shirt and arms. CNA 13 then "egged him on" as he became more agitated. CNA 13 handled Resident D roughly during care. CNA 6 indicated they had just started working at the facility and didn't know what to make of CNA 13's behavior towards the resident, but did feel as if it was abusive. CNA 6 left for the day, then came forward with the observations the next time they were scheduled to work and alerted the Facility Administrator to what they had witnessed. CNA 6 indicated they should have reported what they had witnessed immediately to the Facility Administrator. During an interview on 4/10/23 at 1:15 P.M., the Facility Administrator indicated that CNA 6 was a newer employee and that CNA 13 had intimidated CNA 6. On 4/10/23 at 1:25 P.M., the Facility Administrator supplied employee orientation and training's that CNA 6 had completed. Training's included abuse prevention. On 4/10/23 at 10:20 A.M., the Facility Administrator supplied a facility policy titled, [Facility] Abuse Policy and Procedure, dated 12/30/22. The policy included, "Should an allegation of abuse be suspected, it should be reported immediately to the [Facility]		*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 alert and oriented residents has been conducted as well as observation of the cognitively impaired residents and found no other allegations or evidence of abuse. *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 conducted for all staff on the facility's abuse policy with a focus on immediate reporting to the administrator of any and all allegations of abuse. In addition, the facility has posted reminders in all employee areas of the facility abuse policy as a reminder of reporting all allegations of abuse immediately to the administrator. *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 abuse policy and to ensure that all allegations of abuse are immediately reported to the administrator. This tool will be completed by Social Services and/or their designee weekly for	

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	Administrator." This Federal tag relates to complaint allegation IN00405347. 3.1-28(c)		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.	