

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155539	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Bertha D Garten Ketcham Memorial Center		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E Race St Odon, IN 47562	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>39130</p> <p>Based on observation, interview, and record review, the facility failed to prevent falls for 2 of 3 residents reviewed for accidents. Following falls, 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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Resident C's progress notes included, but were not limited to:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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)</p> <p>Resident D's progress notes included, but were not limited to:</p> <p>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.</p> <p>1/25/25 at 4:06 P.M. - Staff found the resident sitting in front of wheelchair beside bed on floor.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 be put into place . the care plan will be revised based on . new intervention.</p> <p>This citation relates to complaint IN00453338.</p> <p>3.1-45(a)(1)</p>		