STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155539	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bertha D Garten Ketcham Memorial Center	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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and visitors for 9 of 9 rooms tested for hot water. The water temperatures were above 120 degrees. (room [ROOM NUMBER], room [ROOM NUMBER]/38, room [ROOM NUMBER], room [ROOM NUMBER]/34, room [ROOM NUMBER]/24, room [ROOM NUMBER]/26, room [ROOM NUMBER]/36, room [ROOM NUMBER]/12, room [ROOM NUMBER]/16).Findings include: 1.On 1/15/2026 at 10:44 A.M., the water temperature in the bathroom of room [ROOM NUMBER] (private room) was 126.8 degrees Fahrenheit.2. On 1/15/2026 at 10:50 A.M., the water temperature in the bathroom between Rooms 37/38 (bathroom shared with four residents) was 125.7 degrees Fahrenheit. The two residents in room [ROOM NUMBER] were cognitively impaired. The two residents in room [ROOM NUMBER] were cognitively impaired. 3. On 1/15/2026 at 10:53 A.M., the water temperature in the bathroom of room [ROOM NUMBER] (private room) was 126 degrees Fahrenheit. The resident in room [ROOM NUMBER] was cognitively impaired. 4, On 1/15/2026 at 11:06 A.M., the water temperature in the bathroom between Rooms 33/34 (the bathroom was only used by room [ROOM NUMBER] at this time, room [ROOM NUMBER] was empty) was 122.4 degrees Fahrenheit. The two residents in room [ROOM NUMBER] were cognitively impaired.5. On 1/15/2026 at 11:38 A.M., the water temperature in the bathroom between Rooms 23/24 was122.5 degrees Fahrenheit. The water temperature in the bathroom between Rooms 25/26 was122.5 degrees Fahrenheit. Two residents in room [ROOM NUMBER] were cognitively impaired. One resident in room [ROOM NUMBER] was cognitively impaired. 6. On 1/15/2026 at 11:42 A.M., the water temperature in the bathroom between Rooms 35/36 (bathroom shared with four residents) was 122.7 degrees Fahrenheit. One resident in room [ROOM NUMBER] was cognitively impaired.7. On 1/16/26 at 9:04 A.M., the water temperature in the bathroom between Rooms 11/12 was 123.6 degrees Fahrenheit. One resident in room [ROOM NUMBER] was cognitively impaired. 8. On 1/16/25 at 9:08 A.M., the water temperature in the bathroom between Rooms 15/16 was 120.6 degrees Fahrenheit. One resident in room [ROOM NUMBER] was cognitively impaired.9. On 1/21/2026 at 11:46 A.M., the water temperature in the bathroom of room [ROOM NUMBER] was observed to be 124 degrees Fahrenheit.On 1/21/2026 at 11:32 A.M., the Maintenance Supervisor checked the temperature in room [ROOM NUMBER], which was 123 degrees Fahrenheit. The temperature of the water in room [ROOM NUMBER] was 123 degrees Fahrenheit, and room [ROOM NUMBER] was 122.7 degrees Fahrenheit. At that time, the Maintenance Supervisor indicated that when temperatures were over 120, the mixing valve in the building would need to be adjusted. He indicated he had no complaints that the water was too hot and no one had been burned.On 1/22/26 at 10:56 A.M., a policy for water temperatures was requested. The Maintenance Supervisor indicated he did not have a written water temperature policy. There were guidelines that he went by. He indicated the hot water in the showers and sinks must be between 100 to 120 degrees.3.1-19(e)

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the correct resident representative of changes for 1 of 2 residents reviewed for guardianship. A resident deemed by the court to be incompetent, was appointed a guardian (resident's father) but the facility was contacting the father's wife (resident's stepmother) instead. (Resident 6)Finding includes:On 1/21/26 at 9:24 A.M., Resident 6 was observed laying in his bed. Resident made eye contact but gave no verbal responses. He was wearing a hospital gown and had a palm cushion in his right hand.On 1/16/26 at 12:54 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, rhabdomyolysis (a serious condition where damaged muscle tissue breaks down), traumatic brain injury (TBI), contracture of right hand, and persistive vegetative state.The most recent quarterly minimum data set (MDS) assessment, dated 11/11/25, indicated Resident 6's cognitive status was unable to be assessed, and he was totally dependent on staff assistance for eating, toileting, transfers, showers, and bed mobility.The resident's profile tab had listed (stepmother's name) listed first as responsible party, care conference person, and emergency contact #1. The (father's name) was listed second as guardian and emergency contact #2.A circuit court document (guardianship letter), dated and signed by a judge on 3/12/09, indicated the resident's father was assigned his guardian.A current Impaired cognitive function/impaired thought process/ impaired communication Care Plan, last reviewed 11/13/25, included but was not limited to, the following intervention: I am totally dependent on my guardian (father's name) for all decision making. Refer to my guardian for all decisions pertaining to me or my care, initiated 5/14/24Progress notes from 8/1/25 to present were reviewed and included, but were not limited to, the following:8/14/25-Communication with Family Note: Social Services reached out to (stepmother's name) to offer/schedule a quarterly care conference. (Stepmother's name) accepted the offer for a care conference at this time. A care conference has been scheduled for 8/18/25 at 11:00 A.M., via telephone.9/4/25- Interdisciplinary Team (IDT) Note: Nurse reached out to resident's health care representative (HCR) (stepmother's name) about a concern that (doctor's name) had related to resident taking Coumadin. 9/12/25-Health Status Note: Spoke with HCR (stepmother's name) about (doctor's name) changing resident's Coumadin to Eliquis.9/13/25-Communication with Family Note: Was informed of family disagreement with medication change and that family had contacted multiple nurses over multiple shifts about medication change. Spoke directly with (stepmother's name) about the medication change.9/18/25-Social Service Note: Clinical record indicated (stepmother's name) and (Father's name) were contacts (primarily stepmother's name). Guardianship document in Electronic Health Record (EHR).10/23/25- Pharmacy Note: Received pharmacy recommendation to discontinue labs for Coumadin because the resident was no longer taking it. Nurse contacted Medical Doctor (MD). Received orders to discontinue above labs. Resident representative, (stepmother's name), contacted, made aware of changes, and voiced understanding.12/8/25-Social Service Note: Resident was recently moved into a new room (room [ROOM NUMBER]) on 11/28/25 due to a positive covid test and a need to be on isolation precautions. IDT met today and decided it would be in resident's best interest to make the room change permanent and leave him in new room. Responsible party (stepmother's name) made aware of decision to make room change permanent, with (stepmother's name) expressing her agreement with decision and her appreciation for the information and the call.1/9/26-Dietary Progress Note: Registered Dietitian (RD) called (stepmother's name) (POA) to discuss resident gradual weight gain. (Stepmother's name) was not concerned about his current weight but would like for weight to stay around 180 pounds. RD went over calories/protein provided and (stepmother's name) was wanting to decrease feeding but she did not want to change the flush order. Flush order will continue.During an interview on 1/21/26 at 10:42 A.M., the Social Services Director (SSD) indicated the legal guardianship paperwork named (father's name) as the guardian, but (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the facility's purposes, they talk to his wife (stepmother's name). She indicated the facility tried to get stepmother to do Power of Attorney (medical) but that hadn't happened as far as they knew. During an interview on 1/22/26 at 8:59 A.M., Registered Nurse 11 indicated when they need to notify family of a resident, they look under the Profile tab in the EHR and it will have them listed. They call the responsible party listed unless it says not to call them. They are also listed sometimes as emergency contact #1.On 1/21/26 at 4:58 P.M., a current Notification Policy, dated 1/3/23, was provided by the Administrator and indicated, Purpose: To ensure clear, consistent, and timely communication between the facility and a resident's designated contacts when there is a change in the resident's condition, status, or needs. Policy Statement: The facility will identify and utilize resident-designated responsible parties and emergency contacts to communicate significant changes in condition, care needs, transfers, incidents, or other important information . The contacts are then placed in the contact section of the resident profile. Notification Procedure: 1. When a change in condition or significant event occurs, staff will notify contacts in the order listed on the form. 2. The first listed contact is called first. If unable to reach, staff will proceed to the second listed contact, and so on, until contact is made . 3.1-3(c)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure each resident received necessary respiratory care and services in accordance with professional standards of practice for 2 of 5 residents reviewed for respiratory care. The filters on the oxygen concentrators were dusty. (Resident 27, Resident 9)Findings include:1.On 1/15/2026 at 11:42 A.M., Resident 27 was observed sitting in chair next to bed, wearing oxygen at 2 LPM (liters per minute) per nasal cannula. The filter on the oxygen condenser was observed to be dusty.On 1/16/2026 at 12:37 P.M., Resident 27 was observed lying in bed, call light within reach, wearing oxygen at 2 lpm (liters per minute) per nasal cannula. The filter on the oxygen condenser was observed to be dusty.On 1/20/2026 at 9:24 A.M., Resident 27 was observed lying in bed, watching tv, head of the bed elevated, wearing oxygen at 2 lpm (liters per minute) per nasal cannula. The filter on the oxygen condenser was observed to be dusty.On 1/16/2026 at 1:30 P.M., Resident 27's medical records were reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction, affecting right dominant side, and hypoxia.The most recent Quarterly Minimum Data Set (MDS) assessment, dated 12/4/25, indicated Resident 27's cognition was moderately impaired and was receiving oxygen therapy.Current Physician's Orders included, but were not limited to, the following:Supplemental oxygen (O2) at 2-4 LPM per nasal cannula (NC) continuous and humidified to maintain O2 saturation (sat) of greater than 90%. Monitor O2 sat every (q) shift, adjust LPM as needed, and check skin integrity of bilateral ears for any signs and symptoms (s/sx) of breakdown, every day and night shift for shortness of breath (SOB) at rest/hypoxia, ordered 12/5/2024.Wipe down portable oxygen tank and room concentrator and change O2 tubing and humidifier every Sunday on days, ordered 8/17/2025.The clinical record lacked a physician's order related to oxygen concentrator filters.A current hypoxia care plan, dated 12/26/2022, lacked an intervention related to oxygen concentrator filters.2. On 1/15/2026 at 1:54 P.M., Resident 9 was observed sitting in a wheelchair in her room wearing oxygen at 2 LPM (liters per minute) per nasal cannula. At that time, the filter on the back of the oxygen condenser was observed to be dusty.On 1/16/2026 at 12:38 P.M., Resident 9 was observed sitting up in a wheelchair in her room, wearing oxygen at 2 LPM (liters per minute) per nasal cannula. At that time, the filter on the back of the oxygen condenser was observed to be dusty.On 1/20/2026 at 1:50 P.M., Resident 9's medical records were reviewed. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia.The most recent Quarterly Minimum Data Set (MDS) assessment, dated 11/24/2025, indicated Resident 9 was cognitively intact and was receiving oxygen therapy.Current Physician's Orders included, but were not limited to, the following: Change o2 tubing and prefilled humidifier every day shift every Sunday, order date: 8/13/2025 and start Date: 08/17/2025.The clinical record lacked a physician's order related to oxygen concentrator filters.A current impaired gas exchange care plan, last revised 11/19/2024, lacked an intervention related to oxygen concentrator filters.During an interview on 1/21/2026 at 2:15 P.M., Licensed Practical Nurse (LPN) 9 indicated maintenance cleaned the oxygen filters on the oxygen condensers.During an interview on 1/21/2025 at 2:15 P.M., Maintenance Assistant 7 indicated that (name of oxygen provider) cleaned the filters on the oxygen condensers twice a year.During an interview on 1/21/2026 at 2:46 P.M., Central Supply indicated it was (name of oxygen provider) that cleaned the oxygen condenser filters twice a year per (name of oxygen provider's) policy.During an interview on 1/22/2026 at 11:06 A.M., the Administrator indicated (name of oxygen provider) was at the facility the previous week. On 1/22/26 at 12:28 P.M. the contract between (name of oxygen provider) and the facility was reviewed. The contract indicated: All supplies and services rendered to Facility will meet industry standards and quality and shall be delivered in a timely manner. Provider shall provide the services stated in Addendum B. Provider shall also provide safety/instructional materials to the Facility. Specific information related to cleaning the oxygen condenser filters was lacking.On 1/22/26 at 12:28 P.M., a policy for cleaning oxygen condenser filters was requested and not received.3.1-47(a)(6)