STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WALNUT CREEK MEMORY CARE	525 BENTEE WES COURT EVANSVILLE, IN 47715

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00452009, IN00451959, and IN00446043. Complaint IN00452009 - State deficiencies related to the allegations are cited at R036. Complaint IN00451959 - No deficiencies related to the allegations are cited. Complaint IN00446043 - No deficiencies related to the allegations are cited. Survey dates: February 3, 4, 5, 2025. Facility number: 013642 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on interview and record review, the facility failed to notify resident representatives of changes to diet orders for 3 of 3 residents whose families were interviewed. (Resident C, Resident G, and Resident R) Findings include: 1. On 2/4/25 at 9:28 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.	R 0036	As both identified resident and all residents could be affected by deficient practice, corrective action included in-service to all nurses on requirement that both resident's physician and residents legal representative must be notified of change in diet, and that this information must be documented in the resident's health record. To ensure that the same deficient	02/26/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelli Walters	Administrator	02/26/2025

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.

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	The most current Saint Louis University Mental Status (SLUMS) Examination, dated 1/11/25, indicated Resident C was severely cognitively impaired. Diet orders, dated 7/9/24, indicated Resident C received a regular diet. A nursing progress note, dated 2/1/25 at 1:55 P.M., indicated Resident C had been vomiting. A nursing progress note, dated 2/1/25 at 5:15 P.M., indicated Resident C had not vomited since lunch. A nursing progress note, dated 2/2/25 at 10:02 A.M., indicated Resident C had not vomited since 2/1/25 and had eaten half of her breakfast. A nursing progress note, dated 2/3/25 at 8:27 A.M., indicated the physician was notified of gastrointestinal (GI) symptoms in the facility, and a new order had been received for a bland / BRAT (banana, rice, applesauce, toast) diet. During an interview on 2/4/25 at 10:32 A.M., Resident C's son indicated he had not been informed of the change to Resident C's diet from a regular diet to a bland / BRAT diet following the onset of vomiting and diarrhea. At that time, he indicated that sometimes the facility notified Resident C's husband instead of him of changes to her treatment or care. During an interview on 2/5/25 at 9:39 A.M., Resident C's husband indicated he had not been informed of the change to Resident C's diet from a regular diet to a bland / BRAT diet following the onset of vomiting and diarrhea. At that time, he		practice does not reoccur resident health records will be audited for compliance by the Administrator/Designee. The corrective action will be monitored through audit monthly x 3 months, then quarterly for compliance. The results of these audits will be discussed by the Continuous Quality Improvement (CQI) monthly meetings. Systematic changes were in place by 2/27/25	

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	indicated that most information related to Resident C's care got communicated to Resident C's son. 2. On 2/3/25 at 1:54 P.M., Resident G's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most current Saint Louis University Mental Status (SLUMS) Examination indicated Resident G was cognitively impaired Current diet orders, dated 8/6/24, indicated Resident G received a regular diet. A nursing progress note, dated 2/3/25 at 10:00 A.M., indicated the physician was notified of gastrointestinal (GI) symptoms in the facility, and a new order had been received for a bland / BRAT (banana, rice, applesauce, toast) diet. During an interview on 2/4/25 at 11:40 A.M., Resident G's brother indicated he was not aware of the use of the Brat Diet for yesterday lunch (2/3/25) 3. On 2/3/25 at 2:45 P.M., Resident R's clinical record review was reviewed. Diagnosis included, but was not limited to, dementia. The most current Saint Louis University Mental Status (SLUMS) Examination indicated Resident R was severely cognitively impaired. Current diet orders, dated 7/1/22, indicated Resident R received a regular diet. A nursing progress note, dated 2/3/25 at 10:00 A.M., indicated the physician was notified of gastrointestinal (GI) symptoms in the facility, and			

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	a new order had been received for a bland / BRAT (banana, rice, applesauce, toast) diet. POA was notified During an interview on 2/4/25 at 11:20 A.M., Resident R's daughter indicated she did not receive any notification concerning the use of the Brat Diet and she does not get to the facility until she gets off work at 5:00 P.M. On 2/5/25 at 11:08 A.M., the Administrator provided a Change of Condition policy, revised 10/21/24, that indicated "The licensed nurse or designee will notify the Resident's family or responsible party...if the change in condition warrants further medical evaluation, treatment, or alterations to the Resident's evaluation and/or service plan". This citation relates to complaint IN00452009.			
R 0063 Bldg. 00	410 IAC 16.2-5-1.2(gg) Residents' Rights- Noncompliance Based on interview and record review, the facility failed to ensure a resident was allowed to have and use personal belongings in accordance with resident rights. A resident was not allowed to have a cell phone at the facility. (Resident C) Finding includes: On 2/4/25 at 9:28 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most current Saint Louis University Mental Status (SLUMS) Examination, dated 1/11/25, indicated Resident C was severely cognitively	R 0063	As both identified resident and all residents could be affected by deficient practice, corrective action included in-service to all staff that residents have the right to individual expression through retention of personal clothing and belongings, including cell phones. All staff were also instructed that if they are concerned about the possessions of any residents, they are to notify the administrator. Administrator will document family conversations in the EMR. Re-education was	02/26/2025

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	impaired. During an interview on 2/4/25 at 10:32 A.M., Resident C's son indicated the facility took away Resident C's cell phone because the residents have a tendency to lose them. He indicated the only way that he knew to talk to Resident C was to come to the facility and visit her. He indicated the facility never informed him how to reach Resident C by phone once the resident's personal cell phone was removed from the facility. During an interview on 2/4/25 at 12:30 P.M., the Administrator indicated Resident C's husband bought a new cell phone that was too complicated for the resident to use so he returned it to the store. During an interview on 2/5/25 at 9:39 A.M., Resident C's husband indicated he bought Resident C a new cell phone and the facility told him she could not have it because it was too apt to get stolen and they were trying to cut down on what people could steal. He indicated he was not informed on how to reach the resident at the facility after her personal cell phone was taken away. During an interview on 2/5/25 at 11:48 A.M., the Administrator indicated she did not talk about an alternative way for the resident to call out or receive phone calls with Resident C's husband or son after the new cell phone had been removed from the facility. On 2/5/25 at 10:02 A.M., the Administrator provided Resident C's signed Admission Agreement that indicated "The Resident has the right to have and use personal property, space permitting, provided that it does not endanger the		conducted 2/18-19/2025 by Administrator and Nursing Director. To ensure that the same deficient practice does not reoccur, medical records will be audited for compliance by the Administrator/Designee. The corrective action will be monitored through audit monthly x 3 months, then quarterly for compliance. The results of these audits will be discussed by the Continuous Quality Improvement (CQI) monthly meetings. Systematic changes were in place by 2/27/25.	

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	health or safety of others". 410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency Based on interview and record review, the facility failed to report an unusual occurrence within 24 hours of becoming aware of an infection outbreak for 14 of 32 residents and 5 of 35 staff members with symptoms present. Finding includes: During an interview on 2/2/25 at 12:43 P.M., the Administrator indicated multiple residents and staff members were experiencing vomiting, diarrhea, or both but residents were not being isolated. On 2/4/25 at 12:53 P.M., the Director of Nursing provided documents titled Outbreak Log February 2025 that indicated when symptoms started for residents and staff. The following dates indicated the start of symptoms for residents and staff: 2/1/25 - four residents and one staff 2/2/25 - ten residents and four staff 2/3/25 - four residents and one staff 2/4/25 - one resident 2/5/25 - one staff During an interview on 2/5/25 at 10:27 A.M., the Administrator indicated the infection outbreak should have been reported within 24 hours but staff had been too busy to report it. On 2/5/25 at 10:27 A.M., a policy related to reporting infection outbreaks was requested. The Administrator indicated the facility did not have a written policy and the policy was to follow state			
R 0090 Bldg. 00		R 0090	As both identified resident and all residents have potential to be affected by deficient practice, Corrective action included adding follow up to late reported outbreak report including all resident and staff members affected with symptoms of diarrhea and vomiting. Health Service Director (HSD) and Admin were in-serviced on reportable events regulations from ISDH including copies given. To ensure that the same deficient practice does not reoccur, HSD/Designee will review every incident report and any outbreaks with Interdisciplinary Management Team at morning stand up meeting. Interventions put in place and possible need for reporting to ISDH will be discussed. The corrective actions will be monitored through audits of incident reports monthly x 3 months then quarterly for compliance. The results of these audits will be discussed by the Continuous Quality Improvement (CQI) monthly meetings. Systematic changes were in place by 2/27/25.	02/26/2025

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	reporting guidelines.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure at least one staff member was on duty at all times with a current Cardiopulmonary Resuscitation (CPR) Certification in accordance with state laws for 7 of 7 days reviewed. CPR certification did not have a hands on component. Finding includes: On 2/5/25 at 8:30 A.M., staffing was reviewed for the period of 1/24/25 through 1/30/25. On 2/5/25 at 9:05 A.M., CPR certification was provided for Qualified Medication Aide (QMA) 6, Licensed Practical Nurse (LPN) 9, LPN 8, QMA 12, and the Director of Nursing (DON) who worked in the facility during the period of 1/24/25 through 1/30/25. The certifications indicated requirements had been completed though (Name of Health Care Academy). On 2/5/25 at 9:20 A.M., the (Name of Health Care Academy) website was accessed and indicated "Does your course require an outside hands-on or skills test? No. Our interactive training includes step-by-step video demonstrations and detailed illustrations that allow you to practice along at your own pace. This training method will cover and build the skills required to perform CPR, execute basic First Aid procedures, and know how to react when you come into contact with blood. You will be certified upon successfully completing our comprehensive online quiz". During an interview on 2/4/25 at 2:45 P.M., the	R 0117	Corrective action included scheduling on site CPR and first aid training for licensed nursing staff at the facility on March 11, 2025. In addition, the Business Office Manager and Receptionist were in-serviced that the nurses and medications aids must have current certification for both CPR and First aid before having orientation on the floor. Re-education was provided on 2/25/25 by the Administrator. To ensure that the same deficient practice does not occur, employee files will be audited for compliance through Employee File audit tool by Administrator/Designee. Corrective action monitored through audit monthly x 3 months, then quarterly for compliance. The results of these audits will be discussed by the CQI committee. These systematic changes will be completed 3/11/2025	02/26/2025

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	Administrator indicated that the CPR course used to certify staff in CPR and First Aid was online only and contained no in person or hands on component. During an interview on 2/5/25 at 11:08 A.M., the Administrator indicated the facility did not have a policy related to CPR certification, but they followed the state regulations in relation to CPR requirements.			
R 0269 Bldg. 00	410 IAC 16.2-5-5.1(b) Food and Nutritional Services - Noncompliance Based on observation, record review, and interview, the facility failed to notify the dietitian of an approved diet and menu change. The kitchen manager failed to call the dietitian before using BRAT (Banana, Rice, Applesauce, Toast) diet for lunch for 32 of 32 residents. (Kitchen Manager) Finding includes: On 2/3/25 at 11:35 A.M., the lunch menu was observed to be altered to the Brat Diet (special diet banana, rice, applesauce, toast). The scheduled diet was Fried Chicken, Mashed Potatoes, Green Beans, Roll, and Chocolate Meringue Pie had been canceled. On 2/3/25 at 12:00 P.M., during a dining observation the residents were observed eating the rice, broth, and apple sauce for the lunch meal. During an interview on 2/3/25 at 11:35 A.M., the kitchen manager indicated the facility was going to use the Brat Diet for lunch on that day due to an outbreak of emesis and diarrhea. She indicated that she had spoken with the Director of Nursing	R 0269	Corrective action included in-service to Food Service Director that menu changes or substitutions, or both, for all meals shall be approved by a registered dietician. Re-education was completed on 2/25/25 by Administrator. To ensure that the same deficient practice does not reoccur, this will be audited for compliance by the Administrator/Designee. The corrective actions will monitored through an audit monthly x3 months, then quarterly for compliance. The results of these audits will be discussed by the CQI committee. These systematic changes were completed by 2/25/2025.	02/26/2025

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	on the evening of 2/2/25 and again the morning of 2/3/25 about using the Brat Diet. By using Brat diet for lunch, they hoped to head off any problems with all the residents. All thirty-two residents would be having that for lunch on 2/3/25. She indicated that the Brat diet could be found on the Internet. During an interview on 2/3/25 at 11:50 A.M., the kitchen manager indicated she had not notified the dietitian about the diet change before it was implemented. During an interview on 2/4/25 at 8:56 A.M., the dietitian indicated she needs to approve diet changes before implementation. On 2/5/25 at 11:06 A.M., the Administrator provided a current policy "Dining Services Meal Substitutions" revised 12/1/2021. The policy indicated "...when making a meal substitution, document the day, original menu item, reason for the food substitution, initial the substitution on the log, and maintain log...per state regulations."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review, and interview, the facility failed to ensure that food was labeled with the appropriate open and expiration date based on 1 of 2 observation dates of the kitchen. Food containers were found not labeled in kitchen refrigerator and dry storage. (Kitchen) Findings include: On 2/3/25 at 11:18 A.M., during the initial kitchen tour the following was observed in the kitchen	R 0273	All items cited in R273 have been updated or removed from kitchen. As all residents have potential to be affected by the deficient practice, corrective action included in-service with all dietary staff regarding the requirement for all food to be labeled with the appropriate open and expiration date. Re-education was provided by the Food Service Director on 2/26/2025. An audit by the	02/26/2025

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	refrigerator: 1 container of mustard with an open date of 4/1, no best by date or year listed 1 container of ranch dressing with an open date of 10/4 and no best by date or year listed 1 container of soy sauce with an open date of 8/19 and no best by date or year listed 1 container of Teriyaki sauce with an open date of 10/10 and no best by date 1 container of Italian dressing with and open date 8/7 no best by date or year listed 1 container of orange fluid with no label or open date or year listed On 2/3/25 at 11:25 A.M., during the initial kitchen tour the following was observed on the dry storage area shelves: 1 container of Kitchen Brown Seasoning with no open date 1 bottle of Tabasco Sauce with an open date 2/28/20 1 bottle of green food coloring with an open date of 5/30 and no best by date, expiration date, or year listed 1 bottle of red food coloring with an open date of 5/30 and no best by date or year of opening 1 container of cinnamon sticks with an expiration date of 1/26/20 1 container of nut meg with an open date of 3/11 delivery label dated 3/16/22 1 container of instant coffee with an expiration date of Nov/2023 and an open date of 4/18 no year listed 1 bag of peppermint pieces with no open date or year listed 1 box of Ritz Crackers no open date on the box or year listed 1 container of dill with an open date of 3/10 and		Registered Dietician has been scheduled for March. To ensure that the same deficient practice does not reoccur, the dietary department will be audited through use of Dietary Audit as well as scheduled site visits by Dietician biannually. The corrective actions will be monitored through an audit monthly x3 months, then quarterly for compliance by Administrator/Designee results of these audits will be discussed by the CQI committee. These systematic changes were completed by 2/27/25	

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	no best by date or year listed 1 container of ginger with no open date and a delivery label of from 2021 1 container of basil with no open date and a delivery label of 10/3/18 1 container of sage with no open date and an expiration date of 1/23 no year listed During an interview on 2/3/25 at 11:25 A.M., the kitchen manager indicated containers should be thrown away if past expiration/best by date and things should be dated once opened. On 2/5/25 at 11:06 A.M., the Administrator provided a current policy "Food Storage, Handling, and Labeling" revised 12/1/2021. The policy indicated "...all items should have a label indicating date produced and use by date...check labels daily and discard outdated food."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to accurately document notification resident representatives of changes to diet orders for 3 of 3 residents whose families were interviewed. (Resident G, Resident R, Resident C) Findings include: 1. On 2/3/25 at 1:54 P.M., Resident G's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most current Saint Louis University Mental Status (SLUMS) Examination indicated Resident G was cognitively impaired. Current diet orders, dated 8/6/24, indicated	R 0349	As both identified residents and all residents have potential to be affected by deficient practice, corrective action included that all nurses were in-serviced on requirement that all clinical records must be complete, accurate, readily accessible, and organized. Re-education was conducted on 2/25/25 by Administrator and Health Service Director. To ensure that the same deficient practice does not reoccur the resident health records will be audited for compliance by	02/26/2025

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WALNUT CREEK MEMORY CARE	525 BENTEE WES COURT EVANSVILLE, IN 47715

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	Resident G received a regular diet. A nursing progress note, dated 2/3/25 at 10:00 A.M., indicated the physician was notified of gastrointestinal (GI) symptoms in the facility, and a new order had been received for a bland / BRAT (banana, rice, applesauce, toast) diet. The note indicated the Power of Attorney (POA) was notified and updated on the Resident's current condition. During an interview on 2/4/25 at 11:40 A.M., Resident G's brother indicated he was not aware of the use of the Brat Diet for yesterday lunch (2/3/25). 2. On 2/3/25 at 2:45 P.M., Resident R's clinical record review was reviewed. Diagnosis included, but was not limited to, dementia. The most current Saint Louis University Mental Status (SLUMS) Examination indicated Resident R was severely cognitively impaired. Current diet orders, dated 7/1/22, indicated Resident R received a regular diet. A nursing progress note, dated 2/3/25 at 10:00 A.M., indicated the physician was notified of gastrointestinal (GI) symptoms in the facility, and a new order had been received for a bland / BRAT (banana, rice, applesauce, toast) diet. The note indicated the Power of Attorney (POA) was notified and updated on the Resident's current condition. During an interview on 2/4/25 at 11:20 A.M., Resident R's daughter indicated she did not receive any notification concerning the use of the		Administrator/Designee. The corrective actions will be monitored through audit monthly x 3 months, then quarterly for compliance. The results of these audits will be discussed by the Continuous Quality Improvement (CQI) monthly meetings. Systematic changes were in place by 2/27/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Brat Diet and she does not get to the facility until she gets off work at 5:00 P.M.3. On 2/4/25 at 9:28 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most current Saint Louis University Mental Status (SLUMS) Examination, dated 1/11/25, indicated Resident C was severely cognitively impaired. Diet orders, dated 7/9/24, indicated Resident C received a regular diet. A nursing progress note, dated 2/3/25 at 8:27 A.M., indicated the physician was notified of gastrointestinal (GI) symptoms in the facility, and a new order had been received for a bland / BRAT (banana, rice, applesauce, toast) diet. The Power of Attorney (POA) was notified of the new order. During an interview on 2/4/25 at 10:32 A.M., Resident C's son indicated he had not been informed of the change to Resident C's diet from a regular diet to a bland / BRAT diet following the onset of vomiting and diarrhea. At that time, he indicated that sometimes the facility notified Resident C's husband instead of him of changes to her treatment or care. During an interview on 2/5/25 at 9:39 A.M., Resident C's husband indicated he had not been informed of the change to Resident C's diet from a regular diet to a bland / BRAT diet following the onset of vomiting and diarrhea. At that time, he indicated that most information related to Resident C's care got communicated to Resident C's son. On 2/5/25 at 11:08 A.M., the Administrator			

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	provided a Documentation Standards - Resident Health Record policy, revised 3/10/23, that indicated "It is the policy of the Community to maintain a Resident Health Record that reflects the accurate and progressive condition of the Resident, including care provided, interventions and outcomes, in a manner that is consistent with current health care and legal standards of practice ... Falsifications of chart entries will not be tolerated and disciplinary action, up to and including termination, will follow ... Late entry documentation must be noted as such, contain the current date and time and date and time of the occurrence".			