STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/17/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 469131 and 469194. Intake 469131-No deficiencies related to the allegations are cited. Intake 469194- State deficiencies related to the allegations are cited at R053. Survey date: April 17, 2026. Facility number: 013642 Residential Census: 42 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on April 20, 2026.	R 0000		
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w)	R 0053	Employee involved in the investigation has since been terminated. All staff inservices on 4/22/26 and 4/23/26 were	

	(w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure resident's were free from verbal abuse. An employee verbally abused 1 of 3 residents reviewed for abuse. (Resident C) Finding includes: On 4/17/26 at 9:48 a.m., a State reportable with an incident date of 4/14/26 at 8:01 a.m., was reviewed. The report included but was not limited to: Residents involved: [Resident C] Brief description of incident: 4/14/26 Allegations of Verbal Abuse Description added--4/14/26 Housekeeping reports to DON after breakfast that allegedly CNA was in back dining room, resident was noted to be incontinent of urine. CNA yelled at resident "what's wrong with you, you should be ashamed of yourself." Follow up added -4/16/26 After investigation, employee terminated. On 4/17/26 at 10:13 a.m., the DON indicated a housekeeper reported to her that they heard a staff talking inappropriately to a resident during breakfast, the		conducted. No change in behavior or condition were noted after investigated incident. No further directives were noted from family or physician.	

staff was terminated after the investigation.

On 4/17/26 at 10:34 a.m., Resident C's clinical record was reviewed. Diagnoses included but were not limited to, cerebral ischemia, hypertension.

O 4/17/26 at 11:00 a.m., A corrective counseling form dated 4/14/26, was reviewed and included but was not limited to:

" A concern about possible resident abuse was reported to [DON], on 04/14/2026. [CNA 2] was suspended at this time for investigation for verbal abuse on 04/14/2026 during breakfast. This said person that reported the verbal abouse (sic) stated that they heard said employee was yelling at the resident for urinating on the floor and asked why would you do that and you should be ashamed of yourself."

A written statement dated 4/14/26 was reviewed and indicated the housekeeper reported they were cleaning the bathrooms, heard an aide begin yelling that the resident should be ashamed of themselves, and shame on them.

On 4/17/26 at 8:54 a.m., the DON provided the facilities abuse policy with a revision date of 3/10/24. The policy included but was not limited to: This

	community will make every reasonable effort to avoid hiring or continuing to employ persons with a history of or propensity for abuse...Abuse : the willful action or inaction that inflicts injury, unreasonable confinement, intimidating, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, it will be assumed that the abuse caused physical harm, pain, or mental anguish... On 4/17/26 at 10:50 a.m., the DON provided a Resident Rights document that included but was not limited to: ...(D) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality... This citation relates to Intake 469194.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREElizabeth Johnson	TITLEHSD	(X6) DATE05/12/2026