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	04/26/2024

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00432004. Complaint IN00432004 - State deficiencies related to the allegations are cited at R0052 and R0060. Survey date: April 25 and 26, 2024. Facility number: 013642 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 9, 2024.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to protect the resident's rights to be free of neglect, ensure a catheter was properly inserted, and a wound was properly assessed and managed resulting in an emergent hospital stay requiring surgical intervention for 1 of 1 residents reviewed for recent hospital discharges. (Resident C) Findings include:	R 0052	Regional Director of Health Service will reeducate ED/HSD/Designee on Skin Care Oversight guidelines, proper management of catheters, change of condition by May 30, 2024. As all residents could be affected by deficient practice, corrective action included ED/Designee will reeducate all staff on Residents	05/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelli Walters	Administrator	05/23/2024

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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	A confidential interview, on 4/25/24 at 10:01 A.M., a family member disclosed that Resident C was still in the hospital for the pressure wound acquired at the facility, and stated the wound was so severe Resident C has had multiple surgeries to clean the wound, and a surgery where a colostomy was placed due to the amount of tissue loss around the rectal area. The family member disclosed that when family would visit in the morning, Resident C would often be in the same location and position as the evening prior, family were unable to get help from staff, and family frequently would transfer and reposition the Resident themselves. The family was currently looking for a skilled facility to transfer Resident C to due to the facility stating Resident C had to go on hospice services or be transferred to another facility due to the number of staff required for transfers. The family member stated they were not notified of the wound until 4/2/24, and were not told the true severity of the wound until 4/6/24, and would have demanded the Resident be sent to the hospital sooner. On 4/25/24 at 10:01 A.M., Resident C's clinical record was reviewed. Resident C was admitted on 1/8/24. Diagnoses included, but were not limited to, dementia-Alzheimer's, hypertension, and anxiety. Resident was hospitalized 2/16-29/24. The service plan was updated after the hospitalization, dated 3/1/24, indicated the following: Resident C required total staff assistance during incontinence care; staff to change brief and clean up. Resident C's catheter is managed by home health; staff to notify home health for catheter care. Staff to monitor Resident C's skin daily; staff to		Rights, Abuse and Neglect training, reporting daily change in skin condition to Nurse on duty, and Health Service Director to follow up on documentation of Res skin assessment, PCP / POA notification and treatment orders. Treatment implementation in timely manner. ED/Nurse/Health Service Director to review effectiveness of treatment on weekly basis with PCP / POA updated on current skin condition with current treatment order or change in treatment orders, and wound report updated and forwarded to the appropriate parties at the regional level. Regional Director of Health Services will reeducate ED/HSD/Designee on Skin Care Oversight guidelines, proper management of catheters, and change of condition. To ensure the same deficient practice does not reoccur, resident records will be audited weekly x 3 months, and then monthly x 3 month, and then quarterly. Corrective action will be monitored through use of Resident Health Record Audit tool. Results of audit will be reported to QAPI committee at next scheduled meeting. These systematic changes will be	

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	report to supervisor any redness or new skin issues noted on skin. Resident C was non-ambulatory, required total staff assistance for repositioning, and staff assistance of two for transfers. Physician orders included, but were not limited to: Calmoseptine (incontinence barrier ointment) apply to buttocks TID (three times daily), start date 4/2/24. (home health) for F/C (Foley catheter) care/maintenance, dated 3/19/24. A progress note, dated 3/28/24 at 5:02 P.M., indicated purple discoloration to buttocks noted. Family notified and requested Resident stay in the recliner for the remainder of the night; staff notified HSD(Health Service Director/Director of Nursing). A progress note, dated 4/2/24 at 11:19 A.M., indicated a new order was received to start Calmoseptine ointment for the discoloration on Resident C's buttocks. A progress note, dated 4/2/24 at 12:47 P.M., indicated staff entered Resident C's room to lay resident down and found the family had already laid Resident down. A progress note, dated 4/2/24 at 3:59 P.M., indicated Resident C's right and left buttocks were red and deep purple in color. The left inner buttock had a blister that measured 1 cm (centimeter) circular area, an open area that measured 1.2 cm L (length) X 0.6 cm W (width) x 0.1 cm D (depth) and an open area that measured 0.8 cm L X 0.4 cm W x 0.1 cm D. Wound areas were cleansed with wound cleanser and		implemented by 5/30/2024.	

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	Calmoseptine ointment was applied. The clinical record lacked treatment to the buttock areas from 3/28/24 to 4/2/24 at 11:19 A.M. A progress note on 4/3/24 at 10:02 A.M., indicated PCP (primary care physician) notified of change in Resident's buttock area and fluid filled blisters present. PCP will see Resident for face-to-face visit on next visit to facility; family notified. A progress note on 4/5/24 at 12:44 A.M., indicated staff applied Calmoseptine as ordered to buttocks; no improvement noted. The clinical record lacked a PCP (primary care physician) assessment of the buttock wound from 3/28/24 through 4/6/24. A progress note on 4/6/24 at 10:52 A.M., indicated the Calmoseptine ointment was applied to buttocks; buttocks looking worse. Family at facility to visit with Resident and requested to send Resident to hospital due to severity of wound. A wound assessment completed by the DNS on 4/6/24 at 10:30 A.M., indicated wounds under the left and right buttock. Hospital records as follows: Reviewed on 4/25/24 at 11:47 A.M., indicated Resident C arrived via EMS (emergency medical service) to the ED (Emergency Department) on 4/6/24 at 11:47 A.M. An ED Triage Assessment, dated 4/6/24 at 11:50 A.M., indicated Resident C's rectum was inflamed, green, black, and red in color, and was leaking serosanguinous fluid. A physician's note, dated 4/6/24 2:36 P.M, stated			

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	the smell of Resident C's wound was so profound it caused a family member to faint in the ED. CT imaging of the abdomen and pelvis, taken on 4/6/24 at 11:59 A.M., indicated Resident C presented with a malpositioned Foley balloon catheter tip with injury to the prosthetic urethra. A pharmacy progress note, dated 4/7/24 at 1:38 A.M., indicated Resident C began receiving IV (intravenous) Vancomycin (antibiotic) for the infection within the sacral (buttock) wound. Operative and procedure notes, dated 4/7/24 at 3:00 P.M., indicated Resident C received surgical debridement of necrotic perianal tissue and laproscopic diverting of the sigmoid colon for a permanent colostomy. A procedure summary note, dated 4/11/24 at 12:31 P.M., Resident C received a second surgical debridement of the perineal wound and a wound vac was placed. Wound measurements obtained by the hospital from 4/6/24 to 4/16/24, requested on 4/26/24 at 12:40 P.M., were unable to be provided. Multiple photographs taken by hospital staff, dated 4/7/24 through 4/26/24, were provided. The following are dates and measurements from wound evaluation progress notes of the sacral (buttock) wound: 4/17/24 11:15 A.M. 8 cm (length) x 8 cm (width) x 13 cm (depth) 4/19/24 11:46 A.M. 9.4 cm x 7 cm x 11 cm 4/22/24 10:10 A.M. 7.2 cm x 6 cm x 9 cm 4/24/24 12:04 P.M. 7 cm x 5.2 cm x 10.4 cm 4/26/24 11:02 A.M. 8.2 cm x 5 cm x 10.2 cm Hospital photographs received with the hospital record were reviewed. Pre-surgery photo of the			

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	wound appeared to have necrotic tissue, slough and a deep purple color, approximately 7.5 cm in diameter, dated 4/6/24. On 4/7/24 after the first debridement the area increased in appearance to approximately 15 cm irregular shaped. The resident had received two surgerical debridements to the wound on 4/11/24 & 4/17/24. During an interview on 4/25/24 at 2:17 P.M., LPN 4 stated Resident C had a decline in mobility following a hospital stay in February 2024, no longer walked, and required assistance of up to four staff members to transfer at times. LPN 4 stated family would request to leave Resident C in the recliner in the fireplace/TV room, and that it was hard for the CNA's to turn Resident C to be able to change incontinence briefs in that position. LPN 4 stated family was unaware of the severity of the sacral wound until a visit on 4/6/24 where family then requested Resident C be sent to the hospital for evaluation. LPN 4 indicated prior to Resident C's departure, she inserted a new catheter using supplies home health had left in the facility because the home health nurse could not make it to the building before the Resident would be sent to the hospital. During an interview on 4/26/24 at 9:01 A.M., The HSD (Health Service Director/Director of Nursing) stated Resident's skin should be assessed on admission, every 6 months, and if any skin issues arise. She stated if staff find a new skin issue, they report it to her and she evaluates the wound. The HSD states all residents receive barrier cream as a incontinence protection. The HSD states that Resident C's discoloration noted on 3/28/24 had not been assessed by the PCP, and no orders were given for treatment. On 4/2/24, an order for Calmoseptine ointment was provided, without PCP assessment. No further treatments were			

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	provided for Resident C's sacral (buttock) wound. The HSD stated she was aware of LPN 4 inserting a catheter prior to Resident C's hospital transfer on 4/6/24, they did not provide those services at the facility, and home health should have been notified to replace the catheter. The HSD stated she would do whatever it took to get residents qualified for hospice if they become dependent for transfers and require a mechanical lift because the facility can't keep a resident that uses a mechanical lift if they aren't on hospice. On 4/26/24 at 10:39 A.M., Shower sheets and 24 hour Alert charting logs were requested but not provided; the HSD indicated these are done on paper and if there are no skin issues, the papers get shredded. On 4/26/24 at 12:25 P.M., a single weekly wound care report, dated 4/2/24, was provided. A catheter policy was requested on 4/26/24 at 10:39 A.M., but was not provided. A policy titled Skin Care Oversight Guidelines, dated 11/24/22, was provided by the HSD on 4/26/24 at 11:15 A.M., and indicated New skin concerns must be reported to the physician, family, or responsible party, and if required request assistance from third party providers such as home health, hospice, and or a wound care specialist. In addition, the following actions are required: a) Complete an incident report; b) place the resident in Alert Charting for wound oversight; c) Update the resident individualized service plan or care plan to address wound care interventions and d) Place the resident new skin concern on the 24-hour communication report. The HSD will complete the Weekly Wound Care Report every Friday.			

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	A policy titled Documentation Standards-Resident Health Record, dated 11/1/2014 revised 3/10/23, was provided by the HSD on 4/26/24 at 11:15 A.M., and 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 matter that is consistent with current health care and legal standards of practice. Resident Health Records will be retained for at least seven (7) years after the Resident moves from the Community, or per state regulations. The Resident Health Records may be purged according to the following guidelines: A. Never purge...history and physicals. B. After three (3) months...medication and treatment sheets, ADL sheets, care notes. This citation relates to Complaint IN00432004.			
R 0060 Bldg. 00	410 IAC 16.2-5-1.2(dd) Residents' Rights - Deficiency (dd) The facility shall provide reasonable access to any resident, consistent with facility policy, by any entity or individual that provides health, social, legal, and other services to any resident, subject to the resident ' s right to deny or withdraw consent at any time. Based on interview and record review, the facility failed to provide health access to a Resident requiring health services for 1 of 1 Resident's reviewed for catheter care. (Resident C) Findings include: On 4/25/24 at 10:01 A.M., Resident C's clinical record was reviewed. Resident C was admitted on 1/8/24. Diagnoses included, but were not limited	R 0060	As all residents had the potential to be affected, Corrective action will include reeducation on Residents Rights to the Nursing staff and residential regulations about services we are unable to provide including catheter care and certain wound services by ED/HSD. ED/Designee will reeducate HSD/Designee on	05/30/2024

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	to, dementia-Alzheimer's, hypertension, and anxiety. A service plan, dated 3/1/24, indicated the following: Resident will be assisted with the use and care of catheters via family/outside provider. Home health will manage catheter care. Staff to monitor placement and patency. Staff to empty every shift. Staff to notify home health as needed for catheter care. During a confidential interview, on 4/25/24 at 10:01 A.M., a family member disclosed that Resident C had a catheter placed during a recent hospital stay (2/16/24 through 2/29/24) and home health was supposed to manage catheter care at the facility. The family member stated on multiple occasions, home health had called family and stated they had arrived to the facility to provide catheter care, but were turned away by the HSD (Health Service Director/Director of Nursing) stating home health could not see the Resident due to the Resident having behaviors that day. During an interview on 4/26/24 at 10:49 A.M., a home health nurse indicated home health began seeing Resident C on 3/5/24. On 3/6/24, home health was called back to the facility to collect a urine specimen for Resident C. The nurse indicated during the visit on 3/6/24, Resident C was sitting in a wheelchair in the dining room. The nurse was trying to assist Resident C to a private area to collect the urine specimen, but the HSD would not allow the home health nurse to move Resident C. On other occasions home health had attempted to see Resident C and was told Resident C did not need to be seen that day. Home health indicated that they received a resident discharge on 3/22/24 from the HSD but		Resident Rights by May 28,2024. Nursing staff to notify Health Service Director or Administrator for care that is needed for a resident and home health cannot provide in a timely manner then family will be notified of need to send to ER for further evaluation. Ed/Designee will Inservice also included that all Residents' receiving Home Health services are to be allowed access to their client as needed to maintain adequate resident care on an ongoing basis, and that POA's will have choice of which Home Health company to contract with and that outside providers are to have access to their clients when visiting the facility by May 28, 2024. To ensure that the same deficient practice does not reoccur, resident records of those receiving home health services will be audited 2x week for 4 weeks, then weekly ongoing. Corrective action will be monitored through use of Resident Health Record Audit tool. Results of audit will be reported to QAPI committee at next scheduled meeting. These systematic changes will be implemented by 5/30/2024.	

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	were not given explanation why. Documents of facility refusal were requested, but home health indicated only record of completed visits are filed. During an interview on 4/26/24 at 9:01 A.M., the HSD indicated Resident C was discharged from one home health company on 3/22/24 and switched to a different home health on 3/29/24 due to needing a home health company that provided physical therapy services. The HSD indicated there was no home health providing services for Resident C's catheter from 3/22/24 to 3/29/24. The HSD indicated that she chooses the home health company for the Resident and makes the suggestion to the family which home health company to sign a contract with. On 4/26/24 at 12:43 P.M., the HSD provided a copy of Resident C's signed Resident Rights forms that indicated Residents have the right to the following: Choose the attending physician and other providers of services, including arranging for on-site health care services..including home health care agencies. This citation relates to Complaint IN00432004.			