STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITLOCK PLACE	1719 S ELM ST CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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. Survey dates: June 30 & July 1, 2016. Facility number: 004419 Provider number: 004419 AIM number: N/A Census bed type: Residential: 61 Total: 61 Census payor type: Other: 61 Total: 61 Sample: 9 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review completed by 29479.	R 0000		
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation, interview, and record review, the facility failed to ensure documentation of receipt of residents' rights was obtained for 1 of 7 residents reviewed for resident rights (Resident #3). Finding includes: Resident #3's record was reviewed on 7/1/16 at 10:30 a.m. The record lacked documentation Resident #3 had received information on residents' rights upon admission to the facility. During an interview on 7/1/16 at 11:19 a.m., the Executive Director (ED) indicated she could not provide documentation of Resident #3's acknowledgment of residents' rights upon admission. She indicated residents were advised of residents' rights within their	R 0026	R026 1. Resident # 3 was given a copy of the Resident's Rights and has acknowledged receipt in writing, on 7.21.2016. 2. Residents moving into the community have the potential to be affected by the alleged deficient practice. 3. The Executive Director was in-serviced on the requirement for residents to receive a copy of the Resident Rights upon move-in on 7/22/2016 by Amanda Palace, Executive Director. Residents are given a copy of the resident rights and acceptance of these rights is documented by the resident signing the Resident Agreement at move in. 4. The Executive Director is	07/30/2016

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	admission agreement. A policy titled, "Resident Rights," dated 7/1/2014, was provided by the ED on 7/1/16 at 11:19 a.m. The policy indicated, "...A copy of the state-specific resident rights will be given to each resident upon move-in...."		responsible for sustained compliance. The Executive Director or designee will review new Resident Agreements at move-in to identify that the resident rights has been provided to the resident and/or family member, and signature of acknowledgement has been obtained. Monitoring will be ongoing. 5. Completion date: 7/30/16	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			

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	Based on record review and interview, the facility failed to conduct 12 fire drills within a year. Finding includes: On 6/30/16 at 2:30 p.m., the facility fire drills from 6/9/15 to 5/27/16 were reviewed. The "Fire Drill Report" forms indicated fire drills were conducted on 6/9/15, 7/26/15, 9/30/15, 11/23/15, 12/30/15, 1/28/16, 2/26/16, 3/29/16, 4/6/16, and 5/27/16. During an interview on 6/30/16 at 2:30 p.m., the Executive Director (ED) indicated she did not have documentation of fire drills completed in August and October of 2015. She indicated the facility should have conducted 12 fire drills in the past year. On 7/1/16 at 12:56 p.m., the ED provided the facility's fire drill policy, titled "Life Safety" and dated 7/1/2014. This policy indicated, "Fire drills will be performed on a monthly basis and include rotating shifts to ensure employee understanding of fire safety. The results, including any corrective action, are recorded on the designated form and kept on file at the community. Residents participate in drills as required by state-specific regulations...."	R 0092	R092 1. The Maintenance Tech was in-serviced on the fire drill requirement on 7/22/2016 by Executive Director. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Current staff will be in-serviced on 7/28/2016 by Executive Director regarding the requirement for monthly fire drills. 4. The Maintenance Tech is responsible for sustained compliance. The Executive Director and/or designee will review the fire drill reports monthly during the Safety Committee Meetings to ensure compliance. Monitoring will be ongoing. 5. Completion date: 7/30/16	07/30/2016

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R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based observation, interview, and record review, the facility failed to ensure medications were administered as ordered to 1 of 5 residents reviewed for medication administration (Residents #2). Findings include: During an observation on 6/30/16 at 2:16 p.m., Licensed Practical Nurse (LPN) #1 entered Resident #2's apartment for a medication administration. A medication cup containing pills was observed on the resident's kitchen countertop. During an interview on 6/30/16 at 2:17 p.m., LPN #1 indicated the pills in the cup were Resident #2's morning medications that should have been given during the 8:00 a.m. medication administration. LPN #1 indicated the medication had been passed by another staff member. LPN #1 removed the pills	R 0241	R241 1. QMA #3 was re-trained on the proper procedure to stay with the resident during the medication administration process to ensure resident consumed the medications, on 7/1/2016 by Linda LaFoe, Care Service Manager. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Current licensed staff and QMAs were in-serviced on the proper procedure during medication administration to ensure resident consumes medications by the Care Services Manager on 7/11/2016. 4. The Care Services Manager is responsible for sustained compliance. The Care Services Manager and/or designee will audit medication passes five times per week for four weeks, then three times per week for four weeks, then	07/30/2016

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	from the room and notified the Executive Director (ED). During an interview on 6/30/16 at 2:23 p.m., The ED indicated she expected her nursing staff, LPN's and Qualified Medication aides (QMA), to remain with the residents until medications were consumed by resident. Medications were not to be left in resident rooms. The ED indicated QMA # 3 was the staff member in charge of 8:00 a.m., medication administration for Resident #2 on 6/30/16. The ED indicated LPN #1 notified the physician of the missed medication doses. During an interview on 6/30/16 at 2:25 p.m., with the Care Services Director #4, she indicated she expected the nursing staff, LPN's and QMA's, to remain present in the resident room until medications were taken and medications should not be left in their rooms. During an interview on 6/30/16 at 2:30 p.m., LPN #1 indicated the facility policy was medications should not be left in residents rooms and that she always remained in the residents room until the resident consumed the medications. Review of an Medication Administration Record, dated June 1-30, 2016, indicated		weekly for four weeks. The monitoring results will be discussed in monthly QI meetings. The QI committee will determine if continued monitoring is necessary. 5. Completion date: 7/30/2016	

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	facility staff administered Resident #2 with the following daily medications: a. meclizine (treats motion sickness and vertigo) 25 mg (milligrams) one tablet three times daily b. niacin (supplement) 500 mg one tablet daily c. pravastatin (treats high cholesterol) 40 mg one tablet daily d. lisinopril (treats blood pressure) 40 mg tablet daily e. aspirin (pain medication) 325 mg tablet daily f. carbidopa - levodopa (Parkinson's medication) 25 - 100 mg two tablets three times a day g. metformin HCL (oral diabetic medication) 1000 mg tablet twice daily h. diltiazem (treats high blood pressure) 240 mg capsule daily i. glimepride (oral diabetic medicatin) 2 mg twice daily j. fluoxetine HCL (anti-depressant) 20 mg twice daily. On 6/30/16 at 2:31 p.m., the Executive Director (ED) provided the current policy titled, "Medication Administration," ...3. The six "rights" of medication and treatments administration are observed - right resident, right medications, right dose, right form and route, right time, right documentation...."			

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R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review the facility failed to ensure a chest x-ray was completed prior to admission for 1 of 7 residents reviewed for chest x-rays (Resident #7). Finding includes: Resident #7's record was reviewed on 7/1/16 at 11 a.m. A nurse's note dated 1/30/16 at 11:30 p.m. by Licensed Practical Nurse #10 indicated Resident #7 was admitted to the facility. Further review of the record indicated Resident #7 did not have a copy of his chest x-ray. A "REPORT OF TUBERCULOSIS SCREENING EVALUATION" form for Resident #7 indicated section 4. a., " Date of last chest x-ray evaluation", was left blank. A form titled "Tuberculosis Testing Consent and Record" was left bank under the section for chest x-ray. During an interview on 7/1/16 at 12:59 p.m., the Executive Director indicated	R 0408	R408 1. Resident #7 received a chest x-ray on 7/21/2016. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. The Executive Director and the Care Services Manager were re-trained on the chest x-ray requirement 7/1/2016 on by Leigh Brown, Regional Director of Care Services. 4. The Care Services Manager is responsible for sustained compliance. The Executive Director and/or designee will audit new resident move-in records to ensure the chest x-ray has been completed within six months prior to move-in. Monitoring will be ongoing. 5. Completion date: 7/30/2016	07/30/2016

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	they did not have a copy of Resident #7's chest x-ray evaluation. During an interview on 7/1/16 at 1:14 p.m., the Executive Director indicated the facility did not have a policy on chest x-ray's prior to admission, she further indicated they follow the State Regulations, which required the resident receive a chest x-ray within 6 months prior to admission.			