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	01/12/2024

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

(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 the Investigation of Complaint IN00422656. Complaint IN00422656 - State deficiencies related to the allegations are cited at R240 and R117. Survey dates: January 12, 2024 Facility number: 004419 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 23, 2024.	R 0000	Whitlock Place 1719 S Elm St Crawfordsville, IN 47933 Dear Ms. Buroker, On Jan 12,2024 a complaint survey with survey number 0GSH11 was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency.Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 02/08/2024. Please feel free to call me with any further questions on (765) 364-1880. Respectfully submitted, Lasha Batemane Whitlock Place 1719 S Elm St Crawfordsville, IN 47933	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lasha Batemane	Executive Director	02/07/2024

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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	twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure the facility was staffed with a certified Cardio-Pulmonary Resuscitation (CPR) staff member on the overnight shift for 12 of 30 shifts reviewed. Findings include: On 1/12/24 at 1:15 p.m., during an interview with the Executive Director (ED) she indicated they never had only one Certified Nurse Aide (CNA) scheduled at night. If they did not have a volunteer to come in they would cover the shift with a nurse. The ED indicated all of the CNAs were CPR certified. On 1/12/24 at 1:25 p.m., the ED submitted a copy	R 0117	R117 Personal Deficiency The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	02/08/2024

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	of the CNA schedules for November 2023 to January 2024. The documentation indicated on multiple night shifts a staff member who was certified in CPR and first aid, was not scheduled for 12 out of 30 shifts reviewed in the month of November On 1/12/24 at 1:45 p.m., the ED provided a document titled Nursing Audit Tool and indicated it was a current audit of all CNA certifications and CPR certifications. Of the 14 staff members 4 CNAs were not CPR certified. The ED indicated the staff members told her they were certified but she did not have a copy of the CPR certification card to validate training was completed. The ED was unable to provide a policy relating to CPR staff certification. This citation relates to Complaint IN00422656.		required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: All nursing staff will have CPR and first aide certification completed by 02/8/2024. 2)How the facility identified other residents: Any resident residing in the facility had the potential to be affected. Audit completed on all staff to verify the expiration of their CPR and first aide cards. ABOM was educated to keep a logbook with expiration dates of CPR and first aide cards and advise staff to renew it before it expires. 3)Measures put into place/ System changes: DHW/Designee will review schedule daily to ensure that facility has at least 1 person with CPR and first aide certification on all shifts. 4)How the corrective actions will be monitored: DHW/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these	

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			audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 02/08/2024	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview, observation, and record review, the facility failed to follow facility policy/procedure for safe transfer of residents using an assistance device and two staff members during a transfer for 1 of 4 residents reviewed resulting in harm when Resident B sustained rib fractures. Findings include: On 1/12/24 at 10:55 a.m., during routine observation and interview with Resident B the resident indicated in November of last year a Certified Nurse Aide (CNA) 3 picked her up "wrong." She indicated the CNA picked her up from her chair, in a "bear hug" and put her into the bed. She indicated the staff often did that, but she was a two person assist now. The CNA did not use a gait belt at the time. Now they assisted her	R 0240	R240 Health Services The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	02/08/2024

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	with two persons, and they used a gait belt. She indicated she asked to go the emergency room the next day because she had pain in her ribs, was having difficulty breathing, and it was hard to talk. On 1/12/24 at 11:25 a.m., during an interview with the Director of Nursing (DON) she indicated she was notified via phone that the CNA transferred Resident B from her chair into her bed. The resident complained of pain the next day and was sent to the ER. She indicated the ED completed education with all staff after the incident and acknowledged there was no additional specific training or education completed with the CNA who transferred the resident. She did not know if CNA 3 utilized a gait belt when transferring the resident. She indicated Resident B was an assist of one or two prior to the incident. She had updated her care needs to reflect a two person assist for transfers. On 1/12/24 at 11:57 a.m., a review of the medical record indicated Resident B was sent to the hospital on 11/25/24 and returned to the facility with a diagnosis of "closed traumatic minimally displaced fracture of multiple ribs of right side, initial encounter." On 1/12/24 at 12:13 p.m., during interview with CNA 4, the CNA indicated she used a transfer belt for the residents assigned to her. CNA 4 indicated each resident normally had a gait belt in their room and they would use a gait belt when assisting a resident to transfer. They would transfer her from chair to wheelchair then to the bathroom. She indicated the resident was able to stand and bear some weight. When the resident first arrived, she would stand and transfer with only one person but, she had been a two person assist for at least 6 months. CNA 4 indicated there was a task sheet		1)Immediate actions taken for those residents identified: Any resident residing in the facility had the potential to be affected. Resident B resides in the building and her service plan was reviewed and updated with her current transfer status. 2)How the facility identified other residents: Audits will be conducted on residents who had falls from last 30 days and at fall risk to ensure service plans are updated to reflects number of cna required for safe transfers. 3)Measures put into place/ System changes: Inservice and education that included skill evaluation/Skill checks completed for all nursing staff on safe transfers, fall precautions and use of gait belt. DHW/Designee will check 3 nursing personal weekly x 4 weeks, then 2 nursing personals for x 4 weeks and then 1 nursing personal x 4 months to ensure proper transfers techniques are used and use of gait belts for safe transfers. DHW/Designee will review 3 residents weekly x 4 weeks, then	

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	form in their communications binder which told them about the care needs for the residents. On 1/12/24 at 1:15 p.m., the ED indicated she did not have a facility policy for transfers of residents and acknowledged she did not do any additional training or specific skills check off for any CNA's. The ED submitted an in-service training summary dated, 11/25/23 and indicated it was a review of transfers and positioning. On 1/12/24 at 1:25 p.m., review of CNA orientation record. The documentation lacked evidence of skills evaluation relating to job duties. On 1/12/24 at 2:25 p.m., Resident B was observed being transferred from chair to wheelchair by CNA 4 and CNA 5. The CNAs applied a gait belt around the resident's waist and assisted her to stand. The resident was able to bear very minimal weight when standing. She was then assisted to the wheelchair by maximum assist of both CNAs. The CNAs indicated they would not transfer a resident by grabbing them in a bear hug and they both utilized a gait belt at all times to assist a resident to transfer. On 1/12/24 at 2:17 p.m., The ED provided a document titled, "Fall Risk Reduction", dated 2/1/22, and indicated it was the policy currently being used by the facility. The policy indicated,"...Procedure ...Fall risk reduction ...staff training ...the community will train staff on fall risk reduction at orientation and one hour annually ...." This citation relates to Complaint IN00422656.		2 residents weekly x 4 weeks and then 1 resident weekly x 4 month to ensure that their service plan reflects their current transfer status and number of cna required for safe transfers. 4)How the corrective actions will be monitored: DHW/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 02/08/2024	