

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004419	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/10/2024
NAME OF PROVIDER OR SUPPLIER WHITLOCK PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00434716 and IN00436073.</p> <p>Complaint IN00434716 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00436073 - No deficiencies related to the allegations are cited.</p> <p>Survey date: June 10, 2024</p> <p>Facility number: 004419</p> <p>Residential Census: 60</p> <p>Whitlock Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00434716 and IN00436073.</p> <p>Quality review completed on June 12, 2024.</p>	R 000			

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE