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	10/29/2024

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 a State Residential Licensure Survey. Survey dates: October 25, 28, and 29, 2024 Facility number: 004419 Residential Census: 65 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 7, 2024.	R 0000	=”” p=””> Whitlock Place 1719 S Elm St Crawfordsville, IN 47933 Dear Ms. Buroker, On oct 29,2024 an annual survey (**Survey Event ID OFIL11)** 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 NOV 29, 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 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance Based on observation, interview, and record	R 0026	R0026 Resident rights and	11/29/2024

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

Lasha Batemane | Executive Director | 11/20/2024

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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	review, the facility failed to ensure that a copy of resident rights was publicly accessible for 1 of 1 general observations of the facility. Findings include: During a general observation of the facility, on 10/28/24 at 11:00 a.m., the facility failed to have a copy of the resident rights displayed in a publicly accessible area. During an interview, on 10/28/24 at 11:45 a.m., the Assistant Business Office Manager indicated she was not aware of a copy of the resident rights being displayed in the facility. She only knew of the copy that was included in the admission packet when residents were admitted to the facility. During an interview, on 10/28/24 at 11:52 a.m., the Administrator indicated that all residents are given the resident rights upon admission and there was a copy of an 11-page addendum in the activity room down the hallway tacked on the bulletin board. She indicated it was not displayed anywhere else in the facility. On 10/28/24 at 12:12 p.m., the Administrator provided a document, dated 5/22, titled, "Addendum D - Resident Bill of Rights," and indicated it was the current policy being used by the facility. The policy indicated, " ...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 ...."		Noncompliance 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. 1)Immediate actions taken for those residents identified: Resident rights have been displayed in the facility common area. Residents, staff and families were notified. 2)How the facility identified other residents: Any resident residing in the facility had the potential to be affected. No one was affected. 3)Measures put into place/ System changes: DHW/Executive Director will check for placement of resident right 3 times weekly x 4 weeks, 2 times weekly for 4 weeks and 1 time weekly for 4 months. 4)How the corrective actions will be monitored: DHW/Executive Director 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 the 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:11/29/2024	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to ensure boxes of food were stored off the floor in the dry food storage room during 1 of 2 kitchen observations. Findings include: During the initial tour of the kitchen, on 10/25/24 at 10:00 a.m., in the dry food storage room there were 2 boxes of canned goods that were directly on the floor sitting side by side each other. There also were 2 stacks of food boxes that contained approximately 20 boxes in total. The two bottom boxes of the stacks were in direct contact with the floor. During an interview, on 10/25/24 at 10:05 a.m., Cook 3 indicated the food truck had come the previous evening, and she had not had time to put away the boxes of food yet. She indicated the food boxes should not be in contact with the floor. She indicated she was hoping to get the boxes put away later that day if she had help in the kitchen later. During an interview, on 10/25/24 at 10:45 a.m., the	R 0154	R0154 Sanitation and Safety standards. 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. 1)Immediate actions taken for those residents identified: Cook 3 and Dietary staff were reeducated by the administrator on food handling /storage /safety and sanitation. 2)How the facility identified other residents: Any resident residing in the facility had the potential to be affected. No	11/29/2024

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	Dietary Manager indicated they had received the boxes of food the previous evening and they should not have been left on the floor in the dry food storage room. During an interview, on 10/25/25 at 11:00 a.m., the Administrator indicated she had spoken with the dietary staff regarding the boxes of food being left on the floor and the dietary manager should have put them away before she left her shift the previous evening. The boxes should not have been left on the floor. On 10/25/25 at 12:35 p.m., the Administrator provided an undated document, titled, "Food Storage Guidelines," and indicated it was the current policy being used by the facility. The policy indicated, " ...Items larger than individual packets must be removed from the cardboard boxes, dated with the date of delivery and placed on the shelf observing the FIFO rule (First in, First out) ...."		one was affected. 3)Measures put into place/ System changes: Dietary manager/Executive Director will audit kitchen 3 times weekly x 4 weeks, 2 times weekly for 4 weeks and 1 time weekly for 4 months to ensure food storage /sanitation and safety is maintained. 4)How the corrective actions will be monitored: Dietary manager/Executive Director 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 the 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:11/29/2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to obtain food temperatures in a safe and sanitary manner for 1 of 2 kitchen observations. Findings include: During a kitchen observation, on 10/25/24 at 11:45 a.m., Cook 3 placed a thermometer probe in the	R 0273	R 0273 Food and nutritional 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	11/29/2024

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	oven baked cod and obtained a temperature of 148 degrees. The cook proceeded to the sink behind her and grabbed a wet rag from a bucket in the sink. She wiped off the thermometer probe with the rag and put the rag back in the bucket. The Cook then placed the thermometer probe into the baked tomatoes, and wiped the thermometer off with the same wet rag she had gotten from the bucket in the sink. After the baked tomatoes the cook obtained the temperature of the creamy orzo (a short rice-shaped pasta, in a creamy sauce) and then wiped the thermometer probe in the same fashion as previously. During an interview, on 10/25/24 at 11:55 a.m., the Dietary Manager indicated the rag that the cook used to wipe the thermometer probe with was in a bucket in the sink that contained sanitation solutions. During an interview, on 10/25/24 at 1:00 p.m. the Administrator indicated the cook should not have used a wet rag to wipe the thermometer probe with and she would have cross-contaminated the food by using the same rag on the different food items. The administrator indicated she was not aware of a policy that they had about cleaning thermometer probes, but they do follow the Retail Food Establishment guidelines. The Retail Food Establishment Sanitation Requirements, Effective 11/13/24, "Sec. 269. (a) A retail food establishment shall be equipped with at least one (1) of the following options for purposes of washing, rinsing, and sanitizing of equipment and utensils".		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.1)Immediate actions taken for those residents identified:Cook 3 and dietary staff were reeducated by the Dietary manager on proper cleaning of thermometer while checking food temps. 2)How the facility identified other residents:Any resident residing in the facility had the potential to be affected. No one was affected.3)Measures put into place/ System changes:The Dietary manager will audit kitchen staff 3 times weekly x 4 weeks, 2 times weekly for 4 weeks and 1 time weekly for 4 months to ensure proper cleaning is performed while using thermometer to check food temp. 4)How the corrective actions will be monitored:Dietary Manger/Executive director 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 the 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	

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			recommendations to revise the plan of correction as indicated. 5)Date of compliance:11/29/2024.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on record review and interview, the facility failed to maintain an infection control program which had the potential to affect 46 of 46 residents residing in the facility. Findings include: On 10/29/24 at 11:10 a.m., during an interview with the Director of Health and Wellness (DHW) she indicated she did not have a tracking system to monitor ongoing infections and antibiotic treatment. On 10/29/2024 at 1:00 p.m., the provided a document, titled, "Infection control," dated, 6/10/24 and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure 1. The Director of Health and Wellness is responsible for monitoring the on-going compliance with the Community's Infection Control Policies ...The facility must establish an infection control program that includes the following ...a. A system that enables the facility to analyze patterns of known infectious symptoms ...."	R 0407	R0407 Infection control. 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. 1)Immediate actions taken for those residents identified: An infection and antibiotic treatment tracking system has been implemented. 2)How the facility identified other residents: Any resident residing in the facility had the potential to be affected. No one was affected. Audit will be completed by DHW to track resident on antibiotic due to infection and an infection tracking binder will be implemented. 3)Measures put into place/ System changes: DHW will	11/29/2024

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			audit all residents for the last 30 days and any residents on any infection /antibiotic will be added to infection tracking binder. DHW / Designee will audit 3 residents 3 times weekly x 4 weeks, then 2 residents 2 times weekly x 4 weeks and 1 resident 1-time weekly x 4 months to track infections. 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 the 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:11/29/2024.	