

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/15/14</p> <p>Facility Number: 000216 Provider Number: 155323 AIM Number: 100267580</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Whispering Pines Rehabilitation Centre was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms are</p>	K010000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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K010029 SS=E	<p>equipped with battery powered smoke detectors. The facility has the capacity for 80 and had a census of 48 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage which was not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide working automatic door closers on 4 of 10 doors</p>	K010029	1) No residents were affected by this alleged deficient practice. Automatic door closures have been installed on the 4 doors that have been	10/07/2014			

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	<p>providing access to hazardous areas. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. The doors are required to latch. This deficient practice could affect visitors, staff and 25 or more residents in the main dining room and A and B halls.</p> <p>Findings include:</p> <p>1. Based on observation with the maintenance director on 09/15/14 at 11:55 a.m., unoccupied resident room A9 was being used as a storage room. The room was larger than 50 square feet and crowded with furniture, mattresses, cardboard cartons and miscellaneous folded fabric materials. The access door had no means to self close. The maintenance director said at the time of observation, the self closer had been removed.</p> <p>2. Based on observation with the maintenance director on 09/15/14 at 12:35 p.m., the housekeeping supervisor's office served as a storage room for supplies wrapped in paper and cardboard and located on shelving which lined one wall. The room was larger than 50 square feet. The access door had no means to self close. The maintenance</p>		<p>identified as needing automatic door closures.</p> <p>2) All residents have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice. Automatic door closures have been installed on the 4 doors that were identified as needing automatic door closures.</p> <p>3) The maintenance director was re-educated on the requirement of automatic door closures on any room providing access to hazardous areas. The maintenance director and or designee will monitor all hazardous areas weekly to ensure the door closures are working correctly and the doors latch properly so this deficient practice does not recur. Any negative findings will be forwarded to the Administrator immediately.</p> <p>4) The maintenance director and or designee will report the findings of these audits to the QA committee monthly for 3 months then quarterly thereafter and revisions made to the plan if warranted.</p>	

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K010038 SS=E	<p>director acknowledged at the time of observation, the door should have been self closing.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the exit discharge for 1 of 8 exits were readily accessible. LSC 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, staff and 10 or more residents on A Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/15/14 at 11:55 a.m., the exit discharge path from A hall via the service corridor to the parking lot evacuation point was cluttered with 24 cardboard cartons of supplies which diminished the available corridor width to three and a half feet at irregular intervals along the corridor. An interview with the housekeeping supervisor at the time of observation</p>	K010038	<p>1) No residents were affected by this alleged deficient practice. The wheelchair was removed from in front of the exit door on A hall. The cardboard boxes were removed from the service corridor.2) All residents residing on A and B hall have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice. The wheelchair was removed from in front of the exit door on A hall. The cardboard boxes were removed from the service corridor.3) All staff was re educated on ensuring that all exit doors/corridors are maintained free of all obstructions or impediments to full and instant use in case of fire or other emergencies. The maintenance director and or designee will monitor all exit doors/corridors daily to ensure that all exits are maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. Any negative findings will be forwarded to the</p>	10/07/2014			

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K010062 SS=F	<p>revealed the supplies had been delivered "Thursday or Friday." The maintenance director acknowledged at the time of observation, the supplies should have been removed from the hallway before the survey began on 09/15/14, a Monday.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director on 09/15/14 at 2:45 p.m., the Sprinkler System Test Report dated 06/06/14 noted: Air compressor does not fill system in adequate enough time. Recommend new compressor min 50 gal." The maintenance director said at the time of record review, he had replaced the air compressor with a new 30 gal one. He said another contractor</p>	K010062	<p>Administrator immediately.4) The maintenance director and or designee will report the findings of these audits to the QA committee monthly for 3 months then quarterly thereafter and revisions made to the plan if warranted.</p> <p>1) No residents were affected by this alleged deficient practice. A new air compressor was installed so the facility has the recommended 50 gallon air compression to adequately fill the sprinkler system in a timely manner. The sprinkler heads located in the laundry room were replaced. The shower curtain located in the A hall shower room was replaced with an appropriate shower curtain to allow the 18" minimum clearance to protect the shower stall.</p> <p>2) All residents have the potential to be affected by this alleged deficient practice. A new air compressor was installed, sprinkler heads replaced, and shower curtains installed.</p> <p>3) The maintenance director was re-educated on the recommended 50 gallon air compressor to adequately fill the facility's sprinkler system in a timely manner. The</p>	10/07/2014			

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	<p>informed him a 30 gallon compressor was adequate for filling the sprinkler system in a timely manner. There was no documentation or other evidence to support the use of a compressor less than the 30 gallon size recommended by the sprinkler system contractor.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a sprinkler head in 1 of 2 shower/soiled linen collection rooms was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice could affect staff and 3 residents in the A Hall shower room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/15/14 at 12:40 p.m., the middle shower stall in the A Hall shower had a sprinkler located outside the shower stall to provide protection. A solid vinyl shower curtain across the shower stall opening was</p>		<p>maintenance director was re educated on the importance to ensure the facility's sprinkler heads remain clean/corrosion free at all times and he was re educated on shower curtain requirements that provide the minimum 18" clearance to protect the shower stalls. The maintenance director and or designee will check the air compressor daily on working days to ensure that the air compressor adequately fills the facility's sprinkler system in a timely manner. The maintenance director or designee will check the sprinkler heads in the facility weekly to ensure all sprinkler heads remain clean/corrosion free. The maintenance director will also check the shower rooms weekly to ensure the shower curtains are maintained to allow the proper minimum 18" clearance requirements to protect all shower stalls so these alleged deficient practices does not recur. Any negative finding will be reported to the Administrator immediately.</p> <p>4) The maintenance director and or designee will report any negative findings to the QA committee monthly for three months and then quarterly thereafter and revisions made to the plan if warranted.</p>				

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	<p>located twelve inches from the ceiling. The maintenance director acknowledged at the time of observation, the sprinkler head did not have the 18 inch minimum clearance to protect the shower stall.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 2 of 3 sprinkler heads in the laundry were free of foreign materials. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in the central smoke compartment serving A and B Halls.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 09/15/14 at 12:50 p.m., two of three sprinkler heads in the laundry were covered with a gray fuzzy grime. The sprinkler head protecting the area behind the dryers was turning green, usually evidence of corrosion. The maintenance director agreed at the time of observations, the foreign materials could affect the function of the sprinkler heads.</p> <p>b. Based on observation with the maintenance director on 09/15/14 at 1:00 p.m., two sprinklers protecting the</p>			

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K010069 SS=E	<p>mechanical room near the family room were turning green, usually evidence of corrosion.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation, record review and interview; the facility failed to ensure the complete range hood fire extinguishing system was UL 300 approved for 1 of 1 kitchen hood systems. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 7-2.2 requires automatic fire-extinguishing systems shall comply with standard UL 300, Fire Testing of Fire Extinguishing Systems for Protection of Restaurant Cooking Areas. NFPA 96, 3.1 says listed grease filters, baffles or other approved grease removal devices shall be used. Mesh filters shall not be used. This deficient practice could affect kitchen staff, visitors and 10 or more residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on review of the commercial Kitchen Fire Suppression report on 09/15/14 at 2:00 p.m., the Range Guard</p>	K010069	<p>1) No residents were affected by this alleged deficient practice. The facility is having a new UL 300 approved Kitchen hood system installed by Elwood Fire Company on 10-07-2014.</p> <p>2) All residents have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice. A new UL 300 approved kitchen hood system will be installed by Elwood Fire Company on 10-07-2014.</p> <p>3) The maintenance director was re educated on the requirements that the facility must have a UL 300 approved kitchen hood system. The maintenance director and or designee will ensure the hood system is maintained/cleaned in accordance with professional standards. Any negative findings will be forwarded to the Administrator immediately.</p> <p>4) The maintenance director and or designee will report the findings to the QA committee monthly for three months and then quarterly thereafter and revisions made to the</p>	10/07/2014

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K010143 SS=E	<p>hood system was not UL 300. The report noted the system "needs to be updated to UL 300 per NFPA 17A". The maintenance director said at the time of record review, he did not know the system upgrade was needed because the tech had told him "everything was good".</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure liquid oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations, was stored in an area where electrical fixtures were at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires that storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4)</p>	K010143	<p>plan if warranted.</p> <p>1) No residents were affected by this alleged deficient practice. All electrical outlets and switch was removed from the oxygen transferring room 2) All residents have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice. All electrical outlets and switch was removed from the oxygen</p>	10/07/2014

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K010147 SS=E	<p>requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect visitors staff, and 10 or more residents in the core smoke compartment serving the A and B Halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/15/14 at 12:00 p.m., the oxygen storage room had six 181 liter capacity liquid oxygen storage tanks stored in the room. An electrical light switch and two electric receptacles were located 42 inches above the finished floor. The maintenance director acknowledged at the time of observation, these electrical installations were lower than the five foot minimum permitted.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 multi plug adapters was not used as a substitute for fixed wiring. NFPA 70 National</p>	K010147	<p>transferring room.3) The maintenance director and or designee was re educated on the requirements of electrical outlets and switches located in the oxygen transferring room. All outlets and switches were removed to ensure this deficient practice does not recur. The maintenance director and or designee will check the oxygen transferring room weekly to ensure the facility remains in compliance. Any negative findings will be reported to the Administrator immediately.4) The maintenance director and or designee will report any findings of these audits to the QA committee monthly for three months then quarterly thereafter and revisions made to the plan if warranted.</p> <p>1) No residents were affected by this alleged deficient practice. The multi plug adapter was removed from the A/B hall medicine room. 2) All residents residing on A/B hall</p>	10/07/2014			

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	<p>Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables and multi plug adapters shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors, and 10 or more residents in the core smoke compartment serving A and B Halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/15/14 at 12:20 p.m., a multiplug adapter was used to supply power to equipment in the A/B Hall medicine room. The maintenance director acknowledged at the time of observation, the adapter should not have been in use.</p> <p>3.1-19(b)</p>		<p>have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice. The multi plug adapter was removed from the A/B hall medicine room.</p> <p>3) The maintenance director was re educated on the use of the multi plug adapter not being uses as a substitute for fixed wiring. The maintenance director and or designee will check the medicine rooms weekly to ensure no multi plug adapters are being used as a substitute for fixed wiring. Any negative findings will be reported to the Administrator immediately.</p> <p>4) The maintenance director and or designee will report the findings of these audits to the QA committee monthly for three months then quarterly thereafter and revisions made to the plan if warranted.</p>	