

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 06/25/2013
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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: 06/25/13</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 or agreement by the provider of the truths of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	
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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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	<p>equipped with battery powered smoke detectors. The facility has the capacity for 80 and had a census of 50 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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/27/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke barriers in the laundry was maintained to provide at least a one half hour fire resistance rating. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and from outside wall to outside wall. This deficient practice could affect staff, visitors and 10 or more residents in the west lounge and dining rooms open to the laundry smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/25/13 at 2:30 p.m., the ceiling above the commercial washers in the laundry has an eight by thirty six inch cutout covered incompletely by a panel which sagged leaving two inch gaps into the attic above. The panel was observed to have nails</p>	K010025	<p>K025</p> <ol style="list-style-type: none"> No residents were affected by this alleged negative practice. The gaps were filled in and the nails were removed. All residents have the potential to be affected. No residents were affected by this alleged negative practice. The gaps were filled in and the nails were removed. Maintenance Supervisor was re-educated on smoke barriers. The gaps were filled in and the nails were removed. Maintenance Supervisor and/or Designee will monitor all smoke barriers on a monthly basis. Any negative findings will be forwarded to the Administrator immediately. Maintenance Supervisor and/or Designee will report the findings of these audits to the QA committee monthly X3 months then quarterly thereafter, and revisions made to the plan if warranted. 	07/24/2013	

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	<p>which hung down in the sagging panel and attached to nothing. The maintenance director said at the time of observation, there had been a leak "last week" and the panel had not been secured "yet."</p> <p>3.1-19(b)</p>		5. 7-24-13	

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K010029 SS=E	<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 providing access to hazardous areas. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which 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>a. Based on observation with the maintenance director on 06/25/13 at 1:15 p.m., the self closing door to the maintenance shop storing paints and equipment repair materials, stood wide open. The maintenance supervisor said at the time of observation, he pushed the</p>	K010029	<p>K029</p> <p>1. No residents were affected by this alleged negative practice. Maintenance Supervisor and Dietary Staff were re-educated on not propping the self closing or magnetized doors open. A self-closure device was placed on the door to room A9. The shower room door on C hall was repaired to latch properly.</p> <p>2. All residents have the potential to be affected. No residents were affected by this alleged negative practice. Maintenance Supervisor and Dietary Staff were re-educated on not propping the self closing or magnetized doors open. A self-closure device was placed on the door to room A9. The shower room door on C hall was repaired to latch properly.</p> <p>3. Maintenance Supervisor and Dietary Staff were re-educated on not propping the self closing or magnetized doors</p>	07/24/2013			

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	<p>door open to catch the door knob on a shelf behind the door to hold it open because it got hot in there.</p> <p>b. Based on observation with the maintenance director on 06/25/13 at 1:45 p.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, he was unaware the door needed to self close.</p> <p>c. Based on observation with the maintenance director on 06/25/13 at 2:05 p.m., the self closing door between the kitchen dishwashing area and dining room was propped open with a dish cart preventing the self closer from working to close the door. The maintenance director agreed at the time of observation, the door should not have been held open.</p> <p>d. Based on observation with the maintenance director on 06/25/13 at 2:15 p.m., the self closing door between the shower room near the C hall and the exit corridor failed to latch into the door frame without being pulled closed. The room was used for the collection of soiled linen receptacles in excess of 32 gallons which were full. The maintenance director said at the time of observation, he needed to</p>		<p>open. A self-closure device was placed on the door to room A9. The shower room door on C hall was repaired to latch properly. Administrator and/or Designee will do random weekly checks to ensure doors are not propped open and that doors with self-closure or magnets latch properly.</p> <p>4. Administrator and/or Designee will report the findings of these audits to the QA committee monthly X3 months then quarterly thereafter, and revisions made to the plan if warranted.</p> <p>5. 7-24-13</p>				

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K010038 SS=E	<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</p> <p>Based on observation and interview, the facility failed to ensure the exit discharge for 2 of 8 exits was 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 24 residents on A and B Halls.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 05/25/13 at 1:50 p.m., the exit discharge path from A hall to the parking lot evacuation point had eight low hanging tree branches for a distance of ten or more feet which hung across the width of the path of discharge. The branches hung lower than five feet and there was no way to avoid being hit in the face for evacuees using the path. The maintenance director agreed at the time of observation, the limbs interfered with egress. He said he had to cut the tree branches every year and hadn't gotten around to it yet.</p> <p>b. Based on observation with the maintenance director on 06/25/13 at 1:50</p>	K010038	<p>K038</p> <p>1. No residents were affected by this alleged negative practice. Maintenance Supervisor trimmed all tree branches from the egress of A-hall. The vehicle was removed from the no parking zone and all staff were re-educated on proper parking.</p> <p>2. All residents have the potential to be affected. No residents were affected by this alleged negative practice. Maintenance Supervisor trimmed all tree branches from the egress of A-hall. The vehicle was removed from the no parking zone and all staff were re-educated on proper parking.</p> <p>3. Maintenance Supervisor and/or Designee to monitor path of egress on a weekly basis. Administrator and/or Designee to monitor daily on scheduled workdays proper parking of employees and visitors.</p> <p>4. Administrator and/or Designee will report the findings of these audits to the QA committee monthly X3 months then quarterly thereafter, and revisions made to the plan if warranted. Maintenance Supervisor and/or Designee will report the findings of these audits to the QA committee monthly X3 months then quarterly thereafter,</p>	07/24/2013			

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	p.m., the discharge paths from A and B halls converged and terminated at a parking lot. The terminal end of the discharge path was blocked by a parked truck. The maintenance director agreed at the time of observation, the truck would block access to any evacuation vehicle in the event of an emergency. 3.1-19(b)		and revisions made to the plan if warranted. 5. 7-24-13		

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K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure smoking waste was not commingled with combustible materials in 1 of 1 designated smoking areas. This deficient practice affects staff, visitors and 20 or more residents in the main dining room smoke compartment adjacent to the smoking area.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/25/13 at 2:10 p.m., an attached smoking area was</p>	K010066	<p>K066</p> <p>1. No residents were affected by this alleged negative practice. All trash was removed from the metal cigarette butt disposal can and the can was relabeled. All staff was in-serviced on proper use of metal cigarette butt disposal can.</p> <p>2. All residents have the potential to be affected. No residents were affected by this alleged negative practice. All trash was removed from the metal cigarette butt disposal can and the can was relabeled. All staff was in-serviced on proper</p>	07/24/2013			

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	<p>located adjacent to the main dining room. A self closing metal trash can labeled for butt disposal contained paper and plastic wrappers, empty cigarette packs and cigarette butts. The maintenance director said at the time of observation, the practice was not permitted.</p> <p>3.1-19(b)</p>		<p>use of metal cigarette butt disposal can.</p> <p>3. All trash was removed from the metal cigarette butt disposal can and the can was relabeled. All staff was in-serviced on proper use of metal cigarette butt disposal can. Maintenance Supervisor and/or Designee will do random checks 3x/week of metal can for proper disposal of trash and cigarette butts.</p> <p>4. Maintenance Supervisor and/or Designee will report the findings of these audits to the QA committee monthly X3 months then quarterly thereafter, and revisions made to the plan if warranted.</p> <p>5. 7-24-13</p>		

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K010068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code, Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect visitors, staff, and any resident in the corridor where the resident laundry, exercise, and activity rooms are located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/25/13 at 2:00 p.m., the laundry room had two, gas fueled dryers with no fresh air intake. The maintenance director acknowledged at the time of observation, the two gas fueled dryers did not have a fresh air intake.</p> <p>3.1-19(b)</p>	K010068	<p>K068</p> <ol style="list-style-type: none"> No residents were affected by this alleged negative practice. Fresh air intake was placed in laundry room for the gas fueled dryers. All residents have the potential to be affected. No residents were affected by this alleged negative practice. Fresh air intake was placed in laundry room for the gas fueled dryers. Maintenance Supervisor and/or Designee to check the fresh air intake monthly for preventative maintenance. Maintenance Supervisor and/or Designee will report the findings of these audits to the QA committee monthly X3 months then quarterly thereafter, and revisions made to the plan if warranted. 7-24-13 	07/24/2013			

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K010075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to keep 6 of 6 unattended soiled linen and trash collection receptacles with a capacity of more than 32 gallons within a 64 square foot area, in a room protected as a hazardous area. This deficient practice affects visitors, staff and 36 or more residents on A, B and C halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/25/13 between 1:30 p.m. and 3:00 p.m., two soiled linen and trash collection receptacles were observed in the A and in the B corridors with two more in an alcove opening into the corridor on C hall near the shower room. The receptacles were more than half full, exceeded the 32 gallon capacity permitted, and remained in the same position for the duration of</p>	K010075	<p>K075</p> <ol style="list-style-type: none"> No residents were affected by this alleged negative practice. All staff was re-educated on proper placement and storage of all barrels over 32 gallons. All residents have the potential to be affected. No residents were affected by this alleged negative practice. All staff was re-educated on proper placement and storage of all barrels over 32 gallons. Administrator and/or Designee will monitor daily on scheduled workdays at random times to ensure proper placement of barrels is being met. Administrator and/or Designee will report the findings of these audits to the QA committee monthly X3 months then quarterly thereafter, and revisions made to the plan if warranted. 7-24-13 	07/24/2013			

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	the survey. The maintenance director agreed at the times of observation, the carts exceeded the 32 gallon capacity limit. 3.1-19(b)			

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 06/25/2013	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(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			
K010147 SS=E	<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 4 of 4 flexible cords and multitap adapters were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables 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 west lounge and D hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 06/25/13 between 2:05 p.m. and 3:00 p.m., a multitap adapter was used to power two refrigerators and a microwave in the employee break room; a multitap adapter and extension cord were in use in room D7 to provide power for a refrigerator and other equipment. The maintenance director acknowledged at the time of observations, the extension cord should not have been in use to provide power to the equipment, he said he was unaware the multitap adapters were not acceptable.</p>	K010147	<p>K147</p> <ol style="list-style-type: none"> All resident rooms, offices, and staff break room were audited for extension cord use and multi-adapters and any cords in use were removed. All staff re-educated on the use of extension cords and multi-adapters. All residents have the potential to be affected. All resident rooms, offices, and staff break room were audited for extension cord use and multi-adapters and any cords in use were removed. All staff re-educated on the use of extension cords and multi-adapters. Maintenance Supervisor and/or Designee will monitor resident rooms, offices, and staff break room weekly to ensure these items are not in use. Maintenance Supervisor and/or Designee will report the findings of these audits to the QA committee monthly X3 months then quarterly thereafter, and revisions made to the plan if warranted. 7-24-13 	07/24/2013			

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 06/25/2013
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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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	3.1-19(b)			