

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
---	---

(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
K010000	<p>A Post Survey Revisit (PSR) to the PSR conducted on 12/02/13 to the Life Safety Code Recertification and State Licensure Survey conducted on 10/24/13 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/15/14</p> <p>Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this PSR survey, Whispering Pines Health Care Center was found in substantial 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 facility is located in two, two story buildings with walk out lower levels and connected by the "tunnel", a one story</p>	K010000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383		
(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	
	<p>corridor. The two buildings, identified as the Pines and the Manor were determined to be of Type II (111) construction, built prior to March 1, 2003 and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in resident sleeping Rooms # 1 through # 43 and has hard wired smoke detectors supervised by the fire alarm system in all other resident sleeping rooms. The facility has a capacity of 150 and had a census of 113 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/23/14.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
---	---

(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
K010160 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observations, interview and record review; the facility failed to ensure the elevator equipment in 2 of 2 elevator equipment rooms was provided with a shunt trip. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. The elevator equipment rooms were located in the basements of the Manor and Pines buildings and could affect any resident using the elevator as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 01/15/14 at 12:00 p.m. with the Environmental Director, the elevator</p>	K010160	This deficiency has been fully corrected as the boxes for the shunt trips have been installed, along with the shunt trips for both elevators. All documentation has been submitted via fax.	02/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383		
(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	
K019999	<p>equipment rooms located in the basements of the Manor and Pines buildings were provided with a sprinkler head but lacked the presence of a shunt trip which is designed to automatically disconnect power to the affected elevator. Based on record review with the Environmental Director on 01/15/14 after 12:00 p.m., the facility has ordered and received all of the equipment and parts necessary to install the shunt trips except for two panels which were delayed due to weather and they have a contract with an electrician to install after delivery of the panels.</p> <p>This deficiency was cited on 10/24/13 and 12/02/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>	K019999	No deficiency cited. Please advise.	02/07/2014	