

FACILITY EVALUATION REPORT

CCLD Regional Office, 2580 N. FIRST STREET, STE. 350
SAN JOSE, CA 95131

FACILITY NAME: WHISPERING PINES INN, LLC	FACILITY NUMBER: 355201055
ADMINISTRATOR: PARK, CHARLES & MAE	FACILITY TYPE: 740
ADDRESS: 476 LOS VIBORAS ROAD	TELEPHONE: (831) 636-9620
CITY: HOLLISTER	STATE: CA
CAPACITY: 36	CENSUS: 24
TYPE OF VISIT:	UNANNOUNCED
MET WITH: Charles Park	DATE: 08/19/2009
	TIME BEGAN: 08:15 AM
	TIME COMPLETED: 01:20 PM

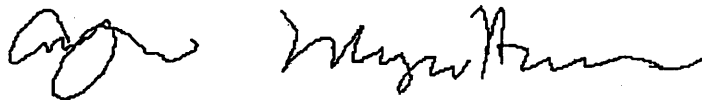
NARRATIVE

1	LPA Aubrey Marks and Margie Harris conducted a case management visit and learned that there were six
2	residents that are bedridden. Facility does not have a bedridden fire clearance. The licensee will submit an
3	LIC 200 and floor plan to CCL to request a bedridden fire clearance.
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6	See LIC809D for Deficiencies cited today.
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8	POC and Appeal rights were discussed during exit interview.
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SUPERVISOR'S NAME: Susan Meyer **TELEPHONE:** (408) 277-1289

LICENSING EVALUATOR NAME: Aubrey Marks **TELEPHONE:** (408) 324-2157

LICENSING EVALUATOR SIGNATURE:



DATE: 08/19/2009

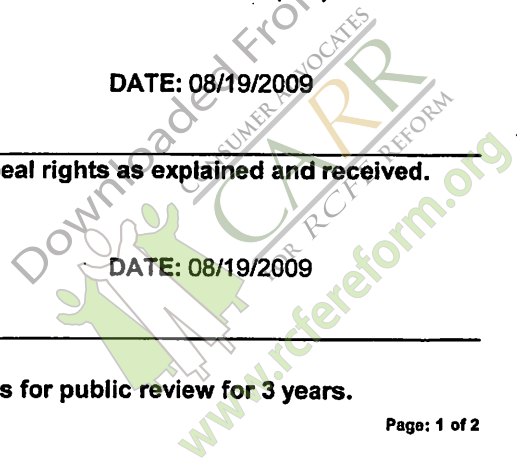
I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 08/19/2009

This report must be available at Child Care and Group Home facilities for public review for 3 years.



FACILITY EVALUATION REPORT (Cont)

FACILITY NAME: WHISPERING PINES INN, LLC
DEFICIENCY INFORMATION FOR THIS PAGE:

FACILITY NUMBER: 355201055
VISIT DATE: 08/19/2009

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type A 08/21/2009 Section Cited 87455(g)	1 Acceptance and Retention limitations: R1-R6 are 2 unable to transfer to and from bed. 3 4 5 6 7	1 Licensee must submit LIC200 to CCL to obtain a 2 bedridden fire clearance by Plan of Correction 3 Date. 4 5 6 7
	1 2 3 4 5 6 7	1 2 3 4 5 6 7
	1 2 3 4 5 6 7	1 2 3 4 5 6 7
	1 2 3 4 5 6 7	1 2 3 4 5 6 7

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISOR'S NAME: Susan Meyer

TELEPHONE: (408) 277-1289

LICENSING EVALUATOR NAME: Aubrey Marks

TELEPHONE: (408) 324-2157

LICENSING EVALUATOR SIGNATURE:

[Handwritten signatures of Susan Meyer and Aubrey Marks]

DATE: 08/19/2009

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

[Handwritten signature of facility representative]

DATE: 08/19/2009

