STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/02/2011
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOME HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN47546	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	An investigation of Complaint Number IN00099324 was conducted by the Indiana State Department of Health. Complaint Number: IN00099324 Substantiated, Federal/State deficiencies related to the allegations cited at F456 and F467. Date of Survey: 11/02/11 Facility Number: 000315 Provider Number: 155720 AIM Number: 100289030 Surveyor: Lex Brashear, Life Safety Code Specialist Census: 58 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/03/11.	F0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulartory obligations. The facility requests this plan of correction be considered our allegation of compliance effective December 2, 2011 to the state findings of the Life Safety Code complaint survey conducted November 2, 2011.	
F0456 SS=F	The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record	F0456	The corrective action put in place for those residents identified as	12/02/2011

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	review, and interview; the facility failed to ensure all essential electrical equipment was in safe operating condition. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation on 11/02/11 at 10:40 a.m. during a tour of the facility with Maintenance person # 1 and the Assistant Supervisor of Environmental Services, the main electrical breaker could not be shut off. Based on interview on 11/02/11 at the time of observation, the Assistant Supervisor of Environmental Services confirmed the main electrical breaker could not be shut off. Based on record review on 11/02/11 at 11:15 a.m. with Maintenance person # 1 and the Assistant Supervisor of Environmental Services present, the facility had a written estimate from 2010 to fix the main breaker. 3.1-19(bb)		being effected by the deficient practice is that no specific residents were identified. The corrective action put in place for those residents having the potential to be effected by the deficient practice is that an electricial contractor was hired to repair the main breaker. The corrective measures put in place to ensure that the deficient practice does not recur is that the maintenance department will test the main breaker monthly to ensure it is functioning properly. The results of the test will be recorded on the main breaker log that has been developed for this purpose. The corrective action put in place to monitor to ensure that the deficient practice does not recur is that the Environmental Service Director will report the results of the main breaker log tests to the Quality Assurance Committee during the quarterly Quality Assurance meeting to see if further action is warranted.	

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F0467 SS=F	The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. Based on observation and interview, the facility failed to ensure 26 of 31 mechanical ventilation fans located on the two roof tops were working. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 11/02/11 between 9:50 a.m. and 10:10 a.m. during a tour of the facility's two roof tops with Maintenance person # 1, twenty six of thirty one mechanical ventilation fans did not work. Based on interview on 11/02/11 at the time of observations, Maintenance person # 1 acknowledged the mechanical ventilation fans were not working, furthermore, Maintenance person # 1 indicated the mechanical ventilation fans were used to provide fresh air, and exhaust other air to and from the resident room bathrooms and corridors in the facility.	F0467	The corrective action put in place for those residents identified as having been effected by the deficient practice is that no residents were identified. The corrective action put in place for those residents having the potential to be effected by the deficient practice is that an electrical contractor was hired to replace the non-functioning exhaust fans. The corrective measures put in place to ensure that the deficient practice does not recur is that the maintenance department will inspect the exhaust fans monthly to ensure they are in proper working order. The results of these inspections will be recorded on the exhaust fan test log developed for this purpose. The corrective action put in place to monitor to ensure that the deficient practice does not recur is that the Environmental Services Deirector will report the results of the exhaust fan test log to the Quality Assurance Committee during the quarterly Quality Assurance meeting to see if further action is warranted.	12/02/2011

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	3.1-19(f)(2)			