STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876

(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
F000000	This visit was for a Recertification and State Licensure survey. Survey Dates: October 28, 29, 30, 31, 2013 and November 1 & 4, 2013 Facility Number: 003624 Provider Number: 155802 AIM Number: 200429840 Survey Team: Mary Weyls RN TC Teresa Buske RN Laura Brashear RN Census Bed Type: SNF/NF: 62 Residential: 30 Total: 92 Census Payor Type: Medicare: 22 Medicaid: 35 Other: 35 Total: 92 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 11/07/2013 by Brenda Marshall Nunan, RN.	F000000	This plan of correction is to serve as Providence Health Care's credible allegation of compliance. Submission of this plan of correction shall not constitute an admission by Providence Health Care to the allegations contained in this survey report. Providence Health Care specifically and generally denies that the survey allegations are indicative of the quality of nursing care and service provided to residents of the health care facility.This plan of correction is submitted in accordance with the requirements of State and Federal law.Providence Health Care hereby requests consideration of a paper compliance re-survey or desk review.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876	

(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
F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation and record review, the facility to ensure visual privacy was maintained during personal care for 2 of 3 random observations which required visual privacy (Residents #56, #39, and #73) Findings include: 1. On 10/30/13 at 4:25 p.m. CNAs #1 and #2 were observed to transfer Resident #56 in her room with a mechanical lift. The resident was suspended in the lift and was wearing a top and incontinence brief. The resident's roommate was in bed in the room, the privacy curtain was not pulled, and Resident #39 was conversing with the CNAs. Resident #39 was not covered and had on a top and incontinence brief. Both residents were in view of each other. Resident #56's clinical record was reviewed on 11/4/13 at 10 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/30/13, coded	F000241	F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITYIt is the practice and policy of Providence Health Care to provide care for the residents in a manner that promotes and maintains each resident's privacy and dignity, as appropriate to each situation and with full recognition of his or her individuality. I. The facility cannot correct the cited concerns for resident #56, resident #39, and resident # 73 as these are past events. The residents have no signs, symptoms or issues related to the cited concern. CNA #1, CNA #2, the Unit Manager #3, LPN #6, and ADON were all re-educated on the resident's right to dignity and respect. II. The facility realizes all residents have the potential to be affected. This has been addressed by the systems described below. III. The facility has reviewed the policy on Resident Rights and Resident Care Standards in relation to privacy, dignity, and respect during provision of care and no concerns were noted. All staff were re-educated on the facility policy. Additional systemic changes are being followed	11/20/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876	

(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
	the resident with severe cognitive impairment, required total assistance of two for transfers, extensive assistance of two for bed mobility, toileting, personal hygiene. Resident #39's clinical record was reviewed on 7/23/13 at 12:09 p.m.. An annual MDS assessment, dated 7/23/13, coded the resident as requiring extensive assist with ADLs (Activities of Daily Living) and severe cognitive impairment. 2. On 10/30/13 at 12:20 p.m. The Unit Manager #3 was observed to perform a dressing change to Resident #73's bottom. The Unit Manager was assisted by LPN #6 and the Assistant Director of Nursing. The resident was positioned on the right side and back and buttocks were exposed towards the doorway. During the dressing change, staff left the bedside to wash hands and change gloves. The resident was not covered when staff were not actively performing treatment. During the dressing change, a CNA knocked on the door, then entered the room, and exited. There was no privacy curtain in the room blocking view from the doorway when door opened.		through our Quality Assurance and Performance Improvement program as indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits regarding the use of practices to provide the resident privacy during provision of care, such as, the use of window blinds, privacy curtains, doors, and signs indicating that personal care is in progress. A random sample of 3 CNA's and 3 licensed nurses are being monitored weekly for 30 days; then 2 times monthly for 30 days; then monthly for 6 months. Additional audits will be completed based upon level of compliance. Results of all audits are reported to the facility Quality Assurance and Performance Improvement Committee for additional recommendations as necessary. Any compliance rate less than 100% will warrant further monitoring on a month by month basis. 100% compliance during the final 3 months of monitoring or for 3 consecutive months after the initial 6 months of monitoring will be presented to Quality Assurance and Performance Improvement Committee for closure of the project. Upon closure of the project, the on-going monitoring will be stopped.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876	

(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
	A Minimum Data Set (MDS) assessment, dated 8/2/13 coded the resident as requiring extensive assistance of two for bed mobility. During review of a facility policy titled "RESIDENT CARE STANDARDS," received from the DON (Director of Nursing) on 11/4/13 at 12:30 p.m., indicated "Resident Rights will be adhered to and privacy and dignity maintained during hygiene measures, treatments or as appropriate to the situation." 3.1-3(t)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876

(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
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review the facility failed to ensure residents were able to make choices for 3 of 3 residents reviewed who preferred more frequent showers and/or a tub bath. (Resident #'s 27, 30, and 72) Findings include: 1. During interview of Resident #30 on 10/29/13 at 11:19 am, the resident indicated, "We're limited to three showers a week. Before I came here, I was used to taking a shower every morning. I would do that if it were possible but that's not how they run things here." During review of Resident #30's clinical record, on 10/30/13 at 1 p.m., an annual MDS (minimum data set), dated 6/4/13, indicated the resident was independent in cognitive decision making. 2. During interview of Resident # 27	F000242	F 242 483.15(b) SELF-DETERMINATION-RIGHT TO MAKE CHOICESIt is the practice and policy of Providence Health Care to provide quality care with full recognition and respect of the resident's right to choose activities, schedules and health care consistent with his or her interests, desires and needs that are significant to the resident. I. The facility cannot correct the cited concerns for resident #30, resident #27, and resident #72 as these have been past events. The residents have no signs or symptoms of adverse effects from the cited concerns. II. The facility realizes all residents have the potential to be affected. This has been addressed by the systems described below. III. The facility has reviewed the policy regarding Resident's Rights, related to free choice and no concerns were noted. All staff were re-educated on the resident's right to make choices about his or her care, schedules, and activities. Every resident was provided information, verbally and	11/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876	

(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
	on 10/30/13 at 10:19 a.m., the resident indicated she did not have a choice concerning the number of showers received during the week. The resident indicated, "The staff did not ask how many showers a week I would like to have. I suppose if there was a reason I would get more showers. I guess they can only do so many showers. They only have one shower. I have a bad back and would love a tub bath but they don't have a tub." During review of Resident #27's clinical record on 10/30/13 at 2 p.m., an annual MDS, dated 5/17/13, indicated the resident was independent in cognitive decision making. The MDS indicated that the resident felt being able to choose between a tub bath and a shower was somewhat important. 3. During interview concerning shower preferences of Resident #72 on 10/30/13 at 1:25 p.m., the resident indicated, "They say it's three times a week. They give me my schedule. My showers are on Tuesday, Thursday and Saturday. It would be nice to have a shower every day, but know I can't. There's too many people."		in writing, on the facility bathing and showering options. They were also interviewed in a private setting with an opportunity to ask questions. Each resident made informed decisions about the type of bath or shower they prefer, the frequency and time of day to be given. The resident's preferences were documented for future reference. Each resident was also informed that these choices could be altered at any time upon their request. The resident's bathing and showering choices were communicated to the direct care staff using care plans, CNA assignment sheets and bath/shower schedules. The resident's bath and shower preferences will be reviewed during routine care plan meetings at least quarterly and as needed. When interviewed, the residents cited in this concern did not change anything about their bathing and showering preferences that were in place at the time of the survey. IV. The Director of Nursing or her designee is conducting quality improvement audits regarding the resident's freedom to choose between bathing options. A random sample of 5 residents will be asked if they are receiving their bath or shower according to their preferences. A random sample of 5 residents will be interviewed weekly for 30 days; then 2 times monthly for 30 days; then monthly for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/04/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876	

(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
	During review of Resident #72's clinical record on 10/30/13 at 2 p.m., an admission minimum data set (MDS), dated 6/6/13, indicated the resident was independent in cognitive decision making. During interview of the Activities Director on 11/4/13 at 12:45 p.m., the director indicated she interviewed the residents about choices, when newly admitted or when an annual assessment was due. The director stated, " I do not indicate residents can have daily showers. I indicate their shower schedule. If they speak up and indicate they want more showers then that would be provided." The Activities Director indicated the facility does have a tub bath available. During review of the facility policy titled "Providence Health Care-Resident Rights," received from the Administrator on 11/4/13 at 3:16 p.m., documentation indicated, "...The Resident has the right to: a) Choose activities, schedules, and health care consistent with her interest, assessments and plans of care:.." 3.1-3(u)(1)		Additional audits will be completed based upon level of compliance. Results of all audits are reported to the Quality Assurance and Performance Improvement Committee for additional recommendations as necessary. Any compliance rate less than 100% will warrant further monitoring on a month by month basis. 100% compliance during the final 3 months of monitoring or for 3 consecutive months after the initial 6 months of monitoring will be presented to Quality Assurance and Performance Improvement Committee for closure of the project. Upon closure of the project, the on-going monitoring will be stopped.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876

(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
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and record review, the facility failed to ensure safety for 1 of 1 random observation of a resident being transferred with a mechanical lift, in that the manufacturer's directions were not followed. (Resident) #56. Finding includes: On 10/30/13 at 4:10 p.m., CNAs (Certified Nurse Aides) #1 and #2 were observed in the process of transferring Resident #56 from the bed to wheelchair with the Invacare Reliant 450 lift. With the base of the lift in the closed position, the resident was raised off of the bed surface. The resident was suspended in the lift sling several inches above chair seat height. The lift was rotated and moved toward the resident's wheelchair. The base of the lift was then opened around the chair, and the resident lowered into the seat. The resident's clinical record was reviewed on 11/4/13 at 11 a.m.	F000323	F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICESIt is the practice and policy of Providence Health Care to provide care for the residents in a manner that is safe and free of accident hazards as is possible. The physical environment shall be maintained in a safe state. Equipment used in the care of the residents are used according to specific manufacturer's directions and precautions. I. The facility cannot correct the cited concerns for resident #56 as this is a past event. The resident has no sign, symptom, or issue related to the cited concern. CNA #1 and CNA #2 were re-educated on the manufacturer's directions for safe use of the Invacare mechanical lift as well as the facility policy to use the lift. Attention was brought to the the positioning of the base of the lift and the height that the resident is lifted off the surface. II. The facility realizes that any resident that is transferred with the use of the mechanical lift has the potential to be affected. III. The facility reviewed the policy regarding the use of the mechanical lift and no concerns	11/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876	

(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
	Diagnoses included, but were not limited to, senile dementia, anxiety, and osteoarthrosis. The Annual Minimum Data Set (MDS) assessment coded the resident with severe cognitive impairment. The quarterly MDS completed on 7/30/13, coded the resident as requiring total assistance of two for transfers extensive assistance of two for bed mobility, and was non-ambulatory. A physician's order dated, 10/21/13, was noted for total assistance of two for transfers, utilize a hoyer lift. Manufacturer's directions for the lift, reviewed on 11/04/13 at 1:00 p.m. , provided by the DON on 11/4/13 at 12:30 p.m., included, but were not limited to: "Warning the legs of the lift must be in maximum open position and the shifter handle locked in place for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to the maximum open position and lock the shifter handle immediately...When the patient is clear of the bed surface swing their feet off the bed...move the		were noted. All CNA's have been re-educated on the facility policy and manufacturer's directions for use of the mechanical lift for resident transfers. All CNA's have re-demonstrated a safe transfer technique using an Invacare mechanical lift during an observed clinical skills validation check-off. Documentation of the skill validation is on file for future reference. Additional systemic changes are being followed through our quality improvement program as indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits regarding the safe use of the Invacare mechanical lift for resident transfers. A random sample of 5 Invacare mechanical lift transfers are being monitored weekly for 30 days; then 2 times monthly for 30 days; then monthly for 6 months. Additional audits will be completed based upon the level of compliance. Results of all audits are reported to the facility Quality Assurance and Performance Improvement Committee for additional recommendations as necessary. Any compliance rate less than 100% will warrant further monitoring on a month by month basis. 100% compliance during the final 3 months of monitoring or for 3 consecutive months after the initial 6 months of monitoring will be presented to Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876

(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
	lift away from the bed when moving the lift away turn patient to face assistant operating the lift, press down button and lower patient so that feet rest on base of lift...The lower center of gravity provides stability making the patient feel more secure and the lift easier to move...." 3.1-45(a)(2)		Improvement Committee for closure of the project. Upon closure of the project, the on-going monitoring will be stopped.	