

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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
G0000	<p>This was a federal home health recertification survey. This survey was partially extended.</p> <p>Facility #: 7180</p> <p>Survey dates: January 9 - 16, 2013</p> <p>Medicaid Vendor #: 200008340A</p> <p>Surveyor: Ingrid Miller, RN, PHNS</p> <p>Census: 1741 skilled unduplicated patients for 2012</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 22, 2013</p>	G0000	No Response.	

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: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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			
G0101	<p>484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.</p> <p>Based on home visit observation, review of the clinical records and agency documents, and interview, the home health agency failed to protect and promote the right of dignity for 1 of 2 home visit observations (patient # 2) with a home health aide with the potential to affect all the patients receiving care from Employee H.</p> <p>Findings</p> <p>1. On January 10, 2013, at 12:10 PM, Employee H, Home Health Aide, was observed to give a bed bath to patient #2. While Employee H washed the patient's genital area, the patient was not draped for privacy.</p> <p>2. Clinical record #2, start of care 10/25/12, contained a document titled "Franciscan Home Services Patient Admission Consent" that was signed by the patient and Employee W, Registered Nurse, on 10/25/12. The document stated, "I have received the patient Bill of Rights and Responsibilities."</p>	G0101	G101 Home Health educators conducted home health aide education on 1/16/2013, focused on patient's rights and the requirement to promote those rights. Aide staff was tested for comprehension of content to promote ongoing compliance. To prevent reoccurrence, patient's rights will be a focus in annual education conducted by Home Health educators. Supervised visits by home care managers will document evidence of respect for patient rights during semi-annual visit observation.	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>3. The agency document titled "Patient Rights and Responsibilities" with no effective date stated, "The patient has the right to be treated with dignity."</p> <p>4. On 1/10/13 at 1 PM, the director of nursing indicated Employee H did not treat the patient with dignity.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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			
G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on home visit observation, policy review, and interview, the agency failed to ensure all employees followed agency policies related to infection control for 4 of 10 (patients #1, #2, #4, and #10) home visit observations resulting in the potential to spread infectious diseases to other patients, family, and staff.</p> <p>Findings</p> <p>1. On 1/10/13 at 9:20 AM, Employee D, licensed practical nurse, was observed to place her nursing bag on the floor near patient #1. There was no barrier observed beneath this bag. Employee D took the patient's blood pressure with a blood pressure cuff and stethoscope. She placed the blood pressure cuff and the stethoscope on the floor after use. Before cleansing the patient's wound, Employee D opened a bottle of already opened normal saline, wrote on the bottle of normal saline, and cleansed the wound by pouring normal saline from this bottle onto a 4 X 4 gauze pad. This bottle had no initials noted for who had opened the bottle and was dated with either 1/3/13 or</p>	G0121	<p>G121 Counseling conducted by Patient Care Coordinator for staff observed during survey process not utilizing infection control practices; (1-18-13). Mandatory education of Infection Control Policies will be held by Home Health educators for skilled and non-skilled staff by 2/15/2013. Competency will be verified with written testing and observation of skills during education program. See attached. To prevent reoccurrence, infection control will continue to be a focus in orientation, annual education. Practice will be identified as a focus of observation during semi-annual Patient Care Coordinator site observations; (2/15/13)</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>1/7/13. Employee D squeezed out neosporin ointment onto a clean 4 X 4 gauze pad and applied this to the second toe of the left foot wound. Employee D discarded the dirty wound dressing and other waste from performing the wound dressing change onto the floor of the patient's home without placing into a garbage bag or rolled into newspaper.</p> <p>On 1/10/13 at 10 AM, the director of nursing indicated the above visit did not comply with agency infection control policies.</p> <p>2. On 1/10/13 at 12:10 PM, Employee H, home health aide, was observed to give a bed bath to patient #2. Before changing the bath water prior to peri care, the aide discarded the dirty gloves and donned new gloves without washing his hands.</p> <p>On 1/10/13 at 1 PM, the director of nursing indicated the above visit did not comply with agency infection control policies.</p> <p>3. On 1/11/13 at 9:20 AM, Employee P, Registered Nurse (RN), was observed to change a wound vac dressing on patient #4. The dressing supplies were placed on the arm and seat of a couch and not all supplies including the sterile wound vac dressing, kerlix, and gauze sponges were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>placed on a barrier. After removing the old dressing including the black foam, the RN was observed to change gloves without washing her hands.</p> <p>On 1/11/13 at 11:15 AM, the director of nursing indicated the above visit did not comply with infection control policies of the agency.</p> <p>4. On 1/14/13 at 1:05 PM, Employee Q, RN, was observed to change an abdominal dressing on patient #10. At this visit, Employee Q removed her gloves after cleansing the wound and donned new gloves without washing her hands. Employee Q cleansed the wound with normal saline from a bottle that was already opened and had not been marked with a date, time, and initials of the staff who had opened the bottle.</p> <p>On 1/14/13 at 1:40 PM, Employee S, RN and alternate director of nursing, indicated Employee Q did not follow infection control policies of the agency.</p> <p>5. The agency policy titled "Infection Control: Handwashing" with an effective date of 10/1/08 stated, "Purpose: Prevent the transfer of disease-producing organisms from person-to-person or place-to-place ... procedure 1. Wash hands ... before and after wearing gloves</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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>... before and after touching wounds or performing wound care."</p> <p>6. The agency policy titled "Infection Control: Handling Wastes and disposables" with an effective date of 10/1/08 stated, "Washing hands and apply nonsterile gloves. ... B. Perform removal of bandages ... C. Wrap dressing soiled with blood or body fluid items in a plastic or paper bag, or roll them up in newspaper."</p> <p>7. The agency policy titled "Infection Control: Nursing Bag Technique" with an effective date of 10/1/08 stated, "In the home, identify a clean and safe area ... to set the bag ... Never set the bag on the floor ... before re - packing the nursing bag clean any reusable equipment with soap and water, alcohol wipes, or program approved disinfectant."</p> <p>8. The agency policy titled "Infection Control: Equipment Cleaning" with an effective date of 12/27/12 stated, "Don nonsterile gloves to protect hands from disinfectants ... stethoscope: routinely clean the bell diaphragm of the stethoscope with a disinfectant spray ... if disinfection of contaminated equipment is not possible in the patient's home, seal in a impermeable plastic trash bag and transport to the home health agency for</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>disinfection. Never place soiled or contaminated equipment in the nursing bag."</p> <p>9. The agency policy titled "Infection Control: Wound care and dressing changes" with an effective date of 10/1/08 stated, "Verify the physician's order for wound care. Gather all the supplies required for the dressing change, such as dressings, tape, scissors, specific treatment items and a disposal bag, and place in a clean area near the patient ... Remove the present dressing by lifting gently, touching only the top part of the clean corner ... discard the contaminated dressing into a disposal bag or wrap in newspaper ... remove and discard gloves and wash hands ... Unwrap the new dressing carefully. Apply a new pair of sterile or nonsterile gloves ... perform the wound care procedure according to the plan of care."</p> <p>10. The agency policy titled "Infection Control: Bag Technique" with no effective date stated, "Once in the patient's home, select the cleanest and most convenient work area and spread the newspaper. Place the bag on the newspaper."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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			
G0128	<p>484.14(b) GOVERNING BODY A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.</p> <p>Based on agency document review, clinical record review, and interview, the governing body failed to ensure the 3 patients of 20 records reviewed (Clinical record 12, 13, and 16) were residents of Indiana (not residents of the state of Michigan) with the potential to affect any patients admitted to services who lived in the state of Michigan.</p> <p>Findings</p> <p>1. The agency document titled "Bylaws of Franciscan Homes & Community Services, INC. Crown Point Indiana" with a review date of January 10, 1996, stated, "Bylaws Preamble Franciscan Homes & Community Services, Inc ... is a not-for-profit Corporation organized and existing under the laws of the state of Indiana."</p> <p>2. An agency document titled "Franciscan Home Care Professional Services" with the signature of the administrator on 12/3/12 stated, "The agency meets current legal requirements for operation ... The governing body functions in accordance within its rules</p>	G0128	G 128 CEO has contacted the Board of Directors to notify them regarding CMS Regulation and no reciprocal agreement between Indiana and Michigan (02/01/2012). Bylaws will not require changes. CEO and COO will investigate CMS application process to potentially include Michigan as a sight of service. Patient Care Coordinator will contact field nurse and begin discharge of Michigan patients (2) to certified providers in Michigan. Process and reason will be shared with patients and then providers agreed upon. Chief Executive Officer and Chief Operating Officer will ensure actions are initiated and completed 2/1/13. Patients from Michigan will not be accepted for service effective 2/1/13. (See Attachment)	03/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>and regulations."</p> <p>3. The agency document titled "Franciscan Home Care Services Geographic Service Area" with no review date showed a map of Berrien County, Michigan with the towns of Harbert, Union Pier, New Buffalo, Three Oaks, and Grand Beach and Lake, Porter, LaPorte, Starke, Jasper, and Newton counties in Indiana.</p> <p>4. Clinical record #12, Start of Care (SOC) 10/22/12, included the patient's name and address in Berrien County, Michigan.</p> <p>5. Clinical record #13, SOC 12/15/12, included the patient's name and address in Berrien County, Michigan.</p> <p>6. Clinical record #16, SOC 11/6/12, included the patient's name and address in Berrien County, Michigan.</p> <p>7. On 1/15/13 at 5 PM, the administrator indicated the agency has had patients in Michigan for years and the area is underserved in home care and is not breaking any laws for either Michigan or Indiana. The administrator also indicated the laws of Michigan do not require that home health agencies be licensed within the state and no agreement laws of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>reciprocity exist between the state of Michigan and the state of Indiana. The administrator stated, "The bottom line is I am meeting the law with our license."</p> <p>8. On 1/16/13 at 10:40 AM, the administrator indicated the by-laws had last been approved in 2000 by the governing body and that the governing body is aware of the patients in Berrien County, Michigan. (The document in finding #1 had a review date of January 10, 1996.) The administrator also indicated the sign in sheet for the last minutes was at the home office in Illinois.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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
G0141	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current.</p> <p>Based on personnel file review, policy review, and interview, the agency failed to ensure the policy was followed regarding a physical examination that evidenced the employee was free of communicable disease for 5 of 21 personnel files reviewed (Files E, F, I, J, and R) with the potential to affect all of the agency's patients.</p> <p>The findings</p> <p>1. The agency policy titled "Health Examinations" with an effective date of 6/99 stated, "Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients."</p> <p>2. Personnel file E, date of hire 4/1/08 and</p>	G0141	<p>G 141Human Resources and Home Care Administration met to discuss requirements of pre-employment physical examination to include additional statement that candidate is "free of communicable disease"; (1/17/2013). Conference with contracted vendor to discuss requirements (1/25/2013). Examination and documentation to meet standards effective 1/25/2013. Physical Examination documentation will be reviewed by Human Resources and Administrative staff to verify inclusion of the additional statement. Effective 1/25/2013. See attached.</p>	01/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>first patient contact 4/3/08, a licensed practical nurse, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>3. Personnel file F, date of hire 9/27/11 and first patient contact 10/7/11, Social Worker, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>4. Personnel file I, date of hire 12/15/12 and first patient contact 12/20/12, Home Health Aide (HHA), failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>5. Personnel file J, date of hire 4/3/09 and first patient contact 4/8/09, HHA, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>6. Personnel file R, date of hire 3/12/10 and first patient contact 3/12/10, Registered Nurse, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>7. On 1/16/13 at 1:15 PM, the alternate</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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	
	administrator indicated the above files lacked a pre-employment physical examination that identified the employees were free of communicable disease.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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			
G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, policy review, home visit observation, and interview, the agency failed to ensure that treatments were completed only as ordered on the plan of care for 4 of 20 records reviewed (#1, #2, #5 and #17) with the potential to affect all patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC)1/4/13, included a plan of care (POC) with a certification period of 1/4/13 - 3/4/13, that failed to evidence the licensed practical nurse (LPN) followed the written POC and there were admission orders at the SOC. This was evidenced by the following:</p> <p>a. The patient's record evidenced a SOC assessment on 1/4/13, skilled nursing visits on 1/7/13 and 1/10/13, and a physical therapist visit on 1/7/13. The admitting orders lacked orders for visits and wound care.</p>	G0158	<p>G158 Educators will develop and conduct mandatory education for skilled staff regarding admission assessments, admission orders and the Plan of Care by 2/15/13. To prevent reoccurrence, Start of Care documentation will be reviewed by Case Coordinator and will be concurrently monitored by QI Coordinator as of 2/15/2013. See attached.</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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>b. On 1/10/13 at 9:20 AM, Employee D, LPN, was observed to cleanse the patient's wound on the second toe of the left foot with normal saline. The order on the POC did not include cleansing the wound with normal saline.</p> <p>c. On 1/10/13 at 4:05 PM, the director of nursing indicated the clinical record lacked admitting orders.</p> <p>2. Clinical record #2, SOC 10/25/12, included a POC with certification period of 12/24/12, that failed to evidence the home health aide (HHA) followed the POC. This was evidenced by the following:</p> <p>a. On January 10, 2013, at 12:10 PM, Employee H, Home Health Aide, was observed to apply Vasolex ointment to the patient's coccyx area and Nystop powder to the patient's groin area and abdominal fold after giving the patient a bed bath.</p> <p>b. The clinical record contained a document titled "Telephony Care Plan Worksheet" printed on 1/10/13 for a routine home health aide routine visit. This document did not include medication assist or application.</p> <p>c. The POC failed to evidence a medication order for Nystop powder.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>d. On 1/10/13 at 1 PM, the director of nursing indicated the aide should not apply Nystop powder or Vasolex ointment and is only allowed by agency policy to do medication assistance.</p> <p>e. On 1/16/13 at 2:15 PM, the director of nursing indicated the definition of medication assistance is the HHA prompting the patient to take a medication and not applying a medication and that any medication applied needs to be on the POC.</p> <p>3. Clinical record #5, SOC 12/26/12, included a plan of care for the certification period of 12/26/12 - 2/23/13, that failed to evidence verbal orders for admission to home care until 1/16/13. This was evidenced by the following:</p> <p>a. A clinical document titled "Order" and dated 1/16/12 and signed by Employee P, Registered Nurse, stated, "Clarification for admission order for admission 12/26/12. New admit to home care for s / p [status / post], fall, pneumonia, uti [urinary tract infection], weakness, shingles, hospitalization 12/19 - 12 /21 per patient request admission 12/26/12 due to holiday SN [skilled nurse], PT / OT [physical therapy / occupational therapy]."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>b. The clinical record included visits for skilled nursing on 12/26/12, 12/28/12, 1/2/13, and 1/9/13; physical therapy on 12/27/12, 12/31/12, 1/2/13, 1/4/13, 1/8/13 and 1/11/13; and occupational therapy on 12/29/12.</p> <p>c. On 1/16/13 at 10:05 AM, the director of nursing indicated there were no orders present in the record to start care.</p> <p>4. Clinical record # 17, SOC 11/28/12, included a plan of care for the certification period of 11/28/12 - 1/26/13 that failed to evidence a verbal admission orders for care until 1/6/13. This was evidenced by the following:</p> <p>a. A clinical document titled "Home Health Certification and Plan of Care" with a certification period of 11/28/12 - 1/26/13 lacked a physician signature. The document included a signature and date of verbal start of care on 11/27/12 and a electronic signature by Employee X, Physical Therapist, on 12/7/12. There was no evidence that any other verbal orders were included in the record to start or initiate physical therapy visits until 1/6/13. Employee X made a visit for a start of care assessment on 11/28/12 and other visits on 11/29/12, 12/4/12, 12/6/12,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>12/11/12, 12/13/12, 12/15/12, 12/18/12, 12/20/12, 12/22/12, and 12/27/12.</p> <p>b. On 1/16/13 at 1:25 PM, Employee A, the director of nursing, indicated that there were no signed physician orders in this record and the physician was out of the office at this time. The physical therapist had failed to obtain any signed orders for care until 1/6/13.</p> <p>5. The agency policy titled "Plan of Treatment / Care" with an effective date of 6/99 and review date of 6/11 stated, "Medical care shall follow a written plan of care established and periodically reviewed by the physician."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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	
G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on home visit observation, clinical record review, interview, and policy review, the agency failed to ensure the plans of care included all the required elements for 3 of 20 records reviewed (#3, #12, #17) creating the potential for omission of care that could affect all of the patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) 12/22/12, included a plan of care (POC) for the certification period 12/22/12 - 2/19/13. This POC failed to include the patient's left arm arteriovenous (AV) fistula for hemodialysis treatment, that was observed at a home visit, and the care and safety precautions that should be present on the POC.</p> <p>a. On 1/10/13 at 1:15 PM, patient #3</p>	G0159	<p>G 159</p> <p>Educators will develop and conduct mandatory education for skilled staff regarding admission assessments, admission orders and the Plan of Care; by 2/15/2013. Comprehension will be verified by written test and ongoing during clinical record review and supervisory visits. To prevent reoccurrence, Start of Care documentation will be reviewed by Case Coordinator and will be concurrently monitored by QI Coordinator as of 2/15/2013. See attached.</p>	02/15/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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>was observed to have a left arm AV fistula.</p> <p>b. Communication notes on 1/4/13 indicated the patient received hemodialysis at DaVita.</p> <p>c. On 1/14/13 at 4:20 PM, Employee Y, Registered Nurse, indicated the patient did have a AV fistula prior to SOC and there was no mention of the fistula in the clinical record or the care needed for this patient receiving hemodialysis.</p> <p>2. Clinical record #12, SOC 10/22/12, included a POC for the certification period of 10/22/12 - 12/20/12 that failed to evidence a timely physician's signature. This was evidenced by the following;</p> <p>a. The POC included a physician signature from 12/13/12.</p> <p>b. On 1/14/13 at 4:45 PM, Employee S, the alternate director of nursing, indicated the physician's signature was late.</p> <p>3. Clinical record # 17, SOC 11/28/12, included a plan of care for the certification period of 11/28/12 - 1/26/13 that failed to evidence physician's signature. This was evidenced by the following:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>a. A clinical document titled "Home Health Certification and Plan of care" with a certification period of 11/28/12 - 1/26/13 lacked a physician signature. The document included a signature and date of verbal start of care on 11/27/12 and an electronic signature by Employee X on 12/7/12.</p> <p>b. On 1/16/13 at 1:25 PM, Employee A, the director of nursing, indicated the POC failed to have a doctor's signature.</p> <p>4. The agency policy titled "Plan of Treatment / Care" with an effective date of 6/99 and review date of 6/11 stated, "The medical plan of care shall be developed in consultation with the home health agency staff and shall cover all pertinent diagnosis ... once the plan of care is completed, it is completed, it is sent to the physicians who will review, sign, date and return within 30 days."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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
G0174	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill.</p> <p>Based on home visit observation, policy review, and interview, the agency failed to ensure the registered nurse (RN) had the specialized skilled to perform wound care in 2 of 2 wound procedures (Home visit observation #4 and #10) observed with a RN with the potential to affect all patients receiving wound care with a RN.</p> <p>Findings</p> <p>1. On 1/11/13 at 9:20 AM, Employee P, Registered Nurse (RN), was observed to change a wound vac dressing on patient #4. The dressing supplies were placed on the arm and seat of a couch and not all supplies including the sterile wound vac dressing, kerlix, and gauze sponges were placed on a barrier. After removing the old dressing including the black foam, the RN was observed to change gloves without washing her hands.</p> <p>On 1/11/13 at 11:15 AM, the director of nursing indicated the above visit did not comply with infection control policies of the agency.</p> <p>2. On 1/14/13 at 1:05 PM, Employee Q, RN, was observed to change an</p>	G0174	<p>G 174 Counseling conducted by Patient Care Coordinator for staff observed during survey process not utilizing infection control practices; (1-18-13). Mandatory education regarding infection control will be held by Home Health educators for skilled and non-skilled staff by 2/15/2013. Competency will be verified with written testing and observation of utilization of infection control skills. See attached. To prevent reoccurrence, infection control will continue to be a focus in orientation, annual education. Actual practice will be a focus of observation during semi-annual Patient Care Coordinator site observation; (2/15/13)</p>	01/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>abdominal dressing on patient #10. At this visit, Employee Q removed her gloves after cleansing the wound and donned new gloves without washing her hands. Employee Q cleansed the wound with normal saline from a bottle that was already opened and had not been marked with a date, time, and initials of the staff who had opened the bottle.</p> <p>On 1/14/13 at 1:40 PM, Employee S, RN and alternate director of nursing, indicated Employee Q did not follow infection control policies of the agency.</p> <p>3. The agency policy titled "Infection Control: Handwashing" with an effective date of 10/1/08 stated, "Purpose: Prevent the transfer of disease-producing organisms from person-to-person or place-to-place ... procedure 1. Wash hands ... before and after wearing gloves ... before and after touching wounds or performing wound care."</p> <p>4. The agency policy titled "Infection Control: Wound care and dressing changes" with an effective date of 10/1/08 stated, "Verify the physician's order for wound care. Gather all the supplies required for the dressing change, such as dressings, tape, scissors, specific treatment items and a disposal bag, and place in a clean area near the patient ...</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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	
	Remove the present dressing by lifting gently, touching only the top part of the clean corner ... discard the contaminated dressing into a disposal bag or wrap in newspaper ... remove and discard gloves and wash hands ... Unwrap the new dressing carefully. Apply a new pair of sterile or nonsterile gloves ... perform the wound care procedure according to the plan of care."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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	
G0179	<p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes services in accordance with agency policy.</p> <p>Based on clinical record review, policy review, home visit observation, and interview, the agency failed to ensure 1 of 1 licensed practical nurse (Employee D) observed at a home visit furnished service in accordance with agency policy with the potential to affect all patients with licensed practical nurse services.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC)1/14/13, included a plan of care (POC) with a certification period of 1/4/13 - 3/4/13, that failed to evidence the licensed practical nurse (LPN) furnished services in accordance with agency policy including setting the nursing bag on the floor, not cleaning equipment as required, not following the POC, using normal saline that had not been labeled correctly, and discarding waste from a dressing change on the floor. This was evidenced by the following:</p> <p>a. On 1/10/13 at 9:20 AM, Employee D, LPN, was observed to change a wound dressing on patient's second left toe that had been partially amputated. When</p>	G0179	<p>G 179 Counseling conducted by Patient Care Coordinator for staff observed during survey process not utilizing infection control practices; (1-18-13). Mandatory education will be held by Home Health educators for skilled and non-skilled staff by 2/15/2013. Competency will be verified with written testing and observation of skills. See attached. To prevent reoccurrence, infection control will continue to be a focus in orientation, annual education. Practice will be a focus of observation during semi-annual Patient Care Coordinator site observation; (2/15/13).</p>	01/18/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>Employee D entered the home, she was observed to place her nursing bag on the floor near patient #1. There was no barrier observed beneath this bag.</p> <p>Employee D took the patient's blood pressure with a blood pressure cuff and stethoscope. She placed the blood pressure cuff and the stethoscope on the floor after use. Before cleansing the patient's wound, Employee D opened a bottle of already opened normal saline, wrote on the bottle of normal saline, and cleansed the wound by pouring normal saline from this bottle onto a 4 X 4 gauze pad. This bottle had no initials noted for who had opened the bottle and was dated either 1/3/13 or 1/7/13. Employee D squeezed out neosporin ointment onto a clean 4 X 4 gauze pad and applied this to the second toe of the left foot wound.</p> <p>Employee D discarded the dirty wound dressing and other waste from performing the wound dressing change onto the floor of the patient's home without placing it into a garbage bag or rolled into newspaper.</p> <p>b. The POC failed to evidence an order to cleans the wound with normal saline as the LPN had done in the above home visit observation.</p> <p>c. On 1/10/13 at 4:05 PM, the director of nursing indicated LPN had not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>followed agency policies.</p> <p>2. The agency policy titled "Infection Control: Handling Wastes and disposables" with an effective date of 10/1/08 stated, "B. Perform removal of bandages ... C. Wrap dressing soiled with blood or body fluid items in a plastic or paper bag, or roll them up in newspaper."</p> <p>3. The agency policy titled "Infection Control: Nursing Bag Technique" with an effective date of 10/1/08 stated, "In the home, identify a clean and safe area ... to set the bag ... Never set the bag on the floor ... before re - packing the nursing bag clean any reusable equipment with soap and water, alcohol wipes, or program approved disinfectant."</p> <p>8. The agency policy titled "Infection Control: Equipment Cleaning" with an effective date of 12/27/12 stated, "Don nonsterile gloves to protect hands from disinfectants ... stethoscope: routinely clean the bell diaphragm of the stethoscope with a disinfectant spray ... if disinfection of contaminated equipment is not possible in the patient's home, seal in a impermeable plastic trash bag and transport to the home health agency for disinfection. Never place soiled or contaminated equipment in the nursing bag."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>9. The agency policy titled "Infection Control: Wound care and dressing changes" with an effective date of 10/1/08 stated, "Verify the physician's order for wound care. Gather all the supplies required for the dressing change, such as dressings, tape, scissors, specific treatment items and a disposal bag, and place in a clean area near the patient ... Remove the present dressing by lifting gently, touching only the top part of the clean corner ... discard the contaminated dressing into a disposal bag or wrap in newspaper ... remove and discard gloves and wash hands ... Unwrap the new dressing carefully. Apply a new pair of sterile or nonsterile gloves ... perform the wound care procedure according to the plan of care."</p> <p>10. The agency policy titled "Infection Control: Bag Technique" with no effective date stated, "Once in the patient's home, select the cleanest and most convenient work area and spread the newspaper. Place the bag on the newspaper."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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
G0225	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on home visit observation, review of the clinical records and agency policies, and interview, the home health agency failed to ensure the home health aide did not apply medications to a patient for 1 of 2 home visit observations (patient #2) with a home health aide (H) with the potential to affect all of the patients cared for by Employee H.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. On January 10, 2013, at 12:10 PM, Employee H, Home Health Aide, was observed to apply Nystop powder to the patient's abdominal fold and groin area and Vasolex to the patient #2's coccyx area after giving the patient a bed bath. 2. Clinical record #2, start of care 10/25/12, contained a document titled "Telephony Care Plan Worksheet" printed on 1/10/13 for a routine home health aide visit. This document did not include medication assist or application. 3. The agency policy titled "Scope of 	G0225	G 225 Mandatory education for aides will be conducted by Home Health educators by 2/15/13 regarding performance of services, permitted, by aides. Education regarding nursing supervision of Home Health Aides includes utilization of prescribed meds. To prevent reoccurrence, competency and understanding will be verified with written test and observed by Patient Care Coordinator during supervisory visits. See attached.	02/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>Service" with a review date of 10/02 stated, "Home Health Aide services - under the direct supervision of the registered nurse are ... medication assistance.</p> <p>4. The agency policy titled "Certified Nursing Assistant [CNA] Visit Protocol" with a review date of 6/99 stated, "The CNA makes scheduled home health care visits to assigned patients ... written instructions for patient from a registered nurse."</p> <p>5. On 1/10/13 at 1 PM, the director of nursing indicated the aide should not apply any topical medications to the patient and should follow the aide care plan.</p> <p>6. On 1/16/13 at 2:15 PM, the director of nursing indicated the definition of medication assistance in finding #3 is the HHA prompting the patient to take a medication and not applying a medication.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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	
G0331	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>Based on home visit observation, clinical record review, interview, and policy review, the agency failed to ensure the initial assessment completed by the registered nurse was complete and accurate for 1 of 10 clinical records reviewed (#3) of patients with home visit observations with the potential to affect all of the patients of the agency.</p> <p>Findings</p> <p>1. On 1/10/13 at 1:15 PM, patient #3 was observed to have a left arm AV fistula. Communication notes on 1/4/13 indicated the patient received hemodialysis at DaVita.</p> <p>a. Clinical record #3 included the initial assessment completed by Employee P, Registered Nurse, on 12/22/12 that failed to include the AV fistula noted in finding #1.</p> <p>b. On 1/14/13 at 4:20 PM, Employee Y, Registered Nurse, indicated the patient</p>	G0331	<p>G 331 Mandatory education will be held by Home Health educators for skilled staff to review Policy # 30.9 and standards of care for the Admission process, by 2/15/2013. To prevent reoccurrence, assessment documentation will be reviewed by nursing management staff for completeness and clarity effective 2/15/2013. Any issue identified through observation at joint visit will be addressed on an individual basis as identified. See attached.</p>	02/15/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>did have a AV fistula prior to start of care and there was no mention of the fistula in the initial assessment.</p> <p>2. The agency policy titled "Admission Process and Comprehensive Admission Assessment" with an effective date of 6/99 and a revised date of 10/03 stated, "C. During the initial assessment, the admitting professional evaluates the patient and situation, using the admission criteria ... II. Purpose ... B. To assess the patient's physical, restorative, psychological, and social needs. C. To collect baseline data about the patient's condition."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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	
N0000	<p>This was a state home health relicensure survey.</p> <p>Facility #: 7180</p> <p>Survey dates: January 9 - 16, 2013</p> <p>Medicaid Vendor #: 200008340A</p> <p>Surveyor: Ingrid Miller, RN, PHNS</p> <p>Census: 1741 skilled unduplicated patients for 2012</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 22, 2013</p>	N0000	No Response.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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	
N0442	<p>410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency.</p> <p>Based on agency document review, clinical record review, and interview, the governing body failed to ensure the 3 patients of 20 records reviewed (Clinical record 12, 13, and 16) were residents of Indiana (not residents of the state of Michigan) with the potential to affect any patients admitted to services who lived in the state of Michigan.</p> <p>Findings</p> <p>1. The agency document titled "Bylaws of Franciscan Homes & Community Services, INC. Crown Point Indiana" with a review date of January 10, 1996, stated, "Bylaws Preamble Franciscan Homes & Community Services, Inc ... is a not-for-profit Corporation organized and existing under the laws of the state of Indiana."</p> <p>2. An agency document titled</p>	N0442	<p>N 442 CEO has contacted the Board of Directors to notify them regarding CMS Regulation and no reciprocal agreement between Indiana and Michigan (02/01/2013). Bylaws will not require changes. CEO and COO will investigate CMS application process to potentially include Michigan as a sight of service. Patient Care Coordinator will contact field nurse and begin discharge of Michigan patients (2) to certified providers in Michigan. Process and reason will be shared with patients and then providers agreed upon. Chief Executive Officer and Chief Operating Officer will ensure actions are initiated and completed 2/1/13. Patients from Michigan will not be accepted for service effective 2/1/13. (See Attachment)</p>	03/07/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>"Franciscan Home Care Professional Services" with the signature of the administrator on 12/3/12 stated, "The agency meets current legal requirements for operation ... The governing body functions in accordance within its rules and regulations."</p> <p>3. The agency document titled "Franciscan Home Care Services Geographic Service Area" with no review date showed a map of Berrien County, Michigan with the towns of Harbert, Union Pier, New Buffalo, Three Oaks, and Grand Beach and Lake, Porter, LaPorte, Starke, Jasper, and Newton counties in Indiana.</p> <p>4. Clinical record #12, Start of Care (SOC) 10/22/12, included the patient's name and address in Berrien County, Michigan.</p> <p>5. Clinical record #13, SOC 12/15/12, included the patient's name and address in Berrien County, Michigan.</p> <p>6. Clinical record #16, SOC 11/6/12, included the patient's name and address in Berrien County, Michigan.</p> <p>7. On 1/15/13 at 5 PM, the administrator indicated the agency has had patients in Michigan for years and the area is</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>underserved in home care and is not breaking any laws for either Michigan or Indiana. The administrator also indicated the laws of Michigan do not require that home health agencies be licensed within the state and no agreement laws of reciprocity exist between the state of Michigan and the state of Indiana. The administrator stated, "The bottom line is I am meeting the law with our license."</p> <p>8. On 1/16/13 at 10:40 AM, the administrator indicated the by-laws had last been approved in 2000 by the governing body and that the governing body is aware of the patients in Berrien County, Michigan. (The document in finding #1 had a review date of January 10, 1996.) The administrator also indicated the sign in sheet for the last minutes was at the home office in Illinois.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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			
N0462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review, policy review, and interview, the agency failed to ensure employees with direct patient contact had a physical examination that showed the employee was free of communicable disease within 180 days of patient contact for 5 of 21 personnel files reviewed (Files E, F, I, J, and R) with the potential to affect all of the agency's patients.</p> <p>The findings</p> <p>1. Personnel file E, date of hire 4/1/08 and first patient contact 4/3/08, a licensed practical nurse, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>2. Personnel file F, date of hire 9/27/11 and first patient contact 10/7/11, Social Worker, failed to evidence a</p>	N0462	<p>N 462 Human Resources and Home Care Administration met to discuss requirements of pre-employment physical examination to include additional statement that candidate is "free of communicable disease"; (1/17/2013). Conference with contracted vendor to discuss requirements (1/25/2013). Examination and documentation to meet standards effective 1/25/2013. To prevent reoccurrence physical examination documentation will be reviewed by Human Resources and Administrative staff to verify inclusion of the additional statement. Effective 1/25/2013. See attached.</p>	01/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>3. Personnel file I, date of hire 12/15/12 and first patient contact 12/20/12, Home Health Aide (HHA), failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>4. Personnel file J, date of hire 4/3/09 and first patient contact 4/8/09, HHA, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>5. Personnel file R, date of hire 3/12/10 and first patient contact 3/12/10, Registered Nurse, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>6. On 1/16/13 at 1:15 PM, the alternate administrator indicated the above files lacked a pre-employment physical examination that identified the employees were free of communicable disease.</p> <p>7. The agency policy titled "Health Examinations" with an effective date of 6/99 stated, "Each employee who will have direct patient contact shall have a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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	
	physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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			
N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on home visit observation, policy review, and interview, the agency failed to ensure all employees followed agency policies related to infection control for 4 of 10 (patients #1, #2, #4, and #10) home visit observations resulting in the potential to spread infectious diseases to other patients, family, and staff.</p> <p>Findings</p> <p>1. On 1/10/13 at 9:20 AM, Employee D, licensed practical nurse, was observed to place her nursing bag on the floor near patient #1. There was no barrier observed beneath this bag. Employee D took the patient's blood pressure with a blood pressure cuff and stethoscope. She placed the blood pressure cuff and the stethoscope on the floor after use. Before cleansing the patient's wound, Employee D opened a bottle of already opened normal saline, wrote on the bottle of normal saline, and cleansed the wound by pouring normal saline from this bottle onto a 4 X 4 gauze pad. This bottle had no initials noted for who had opened the</p>	N0470	<p>N 470 Counseling conducted by Patient Care Coordinator for staff observed during survey process not utilizing infection control practices; (1-18-13). Mandatory education of Infection Control Policies will be held by Home Health educators for skilled and non-skilled staff by 2/15/2013. Competency will be verified with written testing and observation of skills during education program. See attached. To prevent reoccurrence, infection control will continue to be a focus in orientation, annual education. Practice will be identified as a focus of observation during bi-annual Patient Care Coordinator site observations; (2/15/13)</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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>bottle and was dated with either 1/3/13 or 1/7/13. Employee D squeezed out neosporin ointment onto a clean 4 X 4 gauze pad and applied this to the second toe of the left foot wound. Employee D discarded the dirty wound dressing and other waste from performing the wound dressing change onto the floor of the patient's home without placing into a garbage bag or rolled into newspaper.</p> <p>On 1/10/13 at 10 AM, the director of nursing indicated the above visit did not comply with agency infection control policies.</p> <p>2. On 1/10/13 at 12:10 PM, Employee H, home health aide, was observed to give a bed bath to patient #2. Before changing the bath water prior to peri care, the aide discarded the dirty gloves and donned new gloves without washing his hands.</p> <p>On 1/10/13 at 1 PM, the director of nursing indicated the above visit did not comply with agency infection control policies.</p> <p>3. On 1/11/13 at 9:20 AM, Employee P, Registered Nurse (RN), was observed to change a wound vac dressing on patient #4. The dressing supplies were placed on the arm and seat of a couch and not all supplies including the sterile wound vac</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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>dressings, kerlix, and gauze sponges were placed on a barrier. After removing the old dressing including the black foam, the RN was observed to change gloves without washing her hands.</p> <p>On 1/11/13 at 11:15 AM, the director of nursing indicated the above visit did not comply with infection control policies of the agency.</p> <p>4. On 1/14/13 at 1:05 PM, Employee Q, RN, was observed to change an abdominal dressing on patient #10. At this visit, Employee Q removed her gloves after cleansing the wound and donned new gloves without washing her hands. Employee Q cleansed the wound with normal saline from a bottle that was already opened and had not been marked with a date, time, and initials of the staff who had opened the bottle.</p> <p>On 1/14/13 at 1:40 PM, Employee S, RN and alternate director of nursing, indicated Employee Q did not follow infection control policies of the agency.</p> <p>5. The agency policy titled "Infection Control: Handwashing" with an effective date of 10/1/08 stated, "Purpose: Prevent the transfer of disease-producing organisms from person-to-person or place-to-place ... procedure 1. Wash</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>hands ... before and after wearing gloves ... before and after touching wounds or performing wound care."</p> <p>6. The agency policy titled "Infection Control: Handling Wastes and disposables" with an effective date of 10/1/08 stated, "Washing hands and apply nonsterile gloves. ... B. Perform removal of bandages ... C. Wrap dressing soiled with blood or body fluid items in a plastic or paper bag, or roll them up in newspaper."</p> <p>7. The agency policy titled "Infection Control: Nursing Bag Technique" with an effective date of 10/1/08 stated, "In the home, identify a clean and safe area ... to set the bag ... Never set the bag on the floor ... before re - packing the nursing bag clean any reusable equipment with soap and water, alcohol wipes, or program approved disinfectant."</p> <p>8. The agency policy titled "Infection Control: Equipment Cleaning" with an effective date of 12/27/12 stated, "Don nonsterile gloves to protect hands from disinfectants ... stethoscope: routinely clean the bell diaphragm of the stethoscope with a disinfectant spray ... if disinfection of contaminated equipment is not possible in the patient's home, seal in a impermeable plastic trash bag and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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>transport to the home health agency for disinfection. Never place soiled or contaminated equipment in the nursing bag."</p> <p>9. The agency policy titled "Infection Control: Wound care and dressing changes" with an effective date of 10/1/08 stated, "Verify the physician's order for wound care. Gather all the supplies required for the dressing change, such as dressings, tape, scissors, specific treatment items and a disposal bag, and place in a clean area near the patient ... Remove the present dressing by lifting gently, touching only the top part of the clean corner ... discard the contaminated dressing into a disposal bag or wrap in newspaper ... remove and discard gloves and wash hands ... Unwrap the new dressing carefully. Apply a new pair of sterile or nonsterile gloves ... perform the wound care procedure according to the plan of care."</p> <p>10. The agency policy titled "Infection Control: Bag Technique" with no effective date stated, "Once in the patient's home, select the cleanest and most convenient work area and spread the newspaper. Place the bag on the newspaper."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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	
N0494	<p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on home visit observation, review of the clinical records and agency documents, and interview, the home health agency failed to protect and promote the right of dignity for 1 of 2 home visit observations (patient # 2) with a home health aide with the potential to affect all the patients receiving care from Employee H.</p> <p>Findings</p> <p>1. On January 10, 2013, at 12:10 PM, Employee H, Home Health Aide, was observed to give a bed bath to patient #2. While Employee H washed the patient's genital area, the patient was not draped for privacy.</p>	N0494	<p>N 494 Home Health educators conducted home health aide education on 1/16/2013, focused on patient's rights and the requirement to promote those rights. Aide staff was tested for comprehension of content to promote ongoing compliance. To prevent reoccurrence, patient's rights will be a focus in annual education conducted by Home Health educators. Supervised visits by home care managers will document evidence of respect for patient rights during semi-annual visit observation.</p>	01/16/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>2. Clinical record #2, start of care 10/25/12, contained a document titled "Franciscan Home Services Patient Admission Consent" that was signed by the patient and Employee W, Registered Nurse, on 10/25/12. The document stated, "I have received the patient Bill of Rights and Responsibilities."</p> <p>3. The agency document titled "Patient Rights and Responsibilities" with no effective date stated, "The patient has the right to be treated with dignity."</p> <p>4. On 1/10/13 at 1 PM, the director of nursing indicated Employee H did not treat the patient with dignity.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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			
N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, home visit observation, and interview, the agency failed to ensure that treatments were completed only as ordered on the plan of care for 4 of 20 records reviewed (#1, #2, #5 and #17) with the potential to affect all patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC)1/4/13, included a plan of care (POC) with a certification period of 1/4/13 - 3/4/13, that failed to evidence the licensed practical nurse (LPN) followed the written POC and there were admission orders at the SOC. This was evidenced by the following:</p> <p style="padding-left: 40px;">a. The patient's record evidenced a SOC assessment on 1/4/13, skilled nursing visits on 1/7/13 and 1/10/13, and a physical therapist visit on 1/7/13. The admitting orders lacked orders for visits and wound care.</p> <p style="padding-left: 40px;">b. On 1/10/13 at 9:20 AM, Employee</p>	N0522	N 522 Educators will develop and conduct mandatory education for skilled staff regarding admission assessments, admission orders and the Plan of Care by 2/15/2013. Comprehension will be verified by written test and ongoing during clinical record review and supervisory visits. To prevent reoccurrence, Plan of Care documentation will be reviewed by Case Coordinator and will be concurrently monitored by QI Coordinator as of 2/15/2013. See attached.	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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>D, LPN, was observed to cleanse the patient's wound on the second toe of the left foot with normal saline. The order on the POC did not include cleansing the wound with normal saline.</p> <p>c. On 1/10/13 at 4:05 PM, the director of nursing indicated the clinical record lacked admitting orders.</p> <p>2. Clinical record #2, SOC 10/25/12, included a POC with certification period of 12/24/12, that failed to evidence the home health aide (HHA) followed the POC. This was evidenced by the following:</p> <p>a. On January 10, 2013, at 12:10 PM, Employee H, Home Health Aide, was observed to apply Vasolex ointment to the patient's coccyx area and Nystop powder to the patient's groin area and abdominal fold after giving the patient a bed bath.</p> <p>b. The clinical record contained a document titled "Telephony Care Plan Worksheet" printed on 1/10/13 for a routine home health aide routine visit. This document did not include medication assist or application.</p> <p>c. The POC failed to evidence a medication order for Nystop powder.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>d. On 1/10/13 at 1 PM, the director of nursing indicated the aide should not apply Nystop powder or Vasolex ointment and is only allowed by agency policy to do medication assistance.</p> <p>e. On 1/16/13 at 2:15 PM, the director of nursing indicated the definition of medication assistance is the HHA prompting the patient to take a medication and not applying a medication and that any medication applied needs to be on the POC.</p> <p>3. Clinical record #5, SOC 12/26/12, included a plan of care for the certification period of 12/26/12 - 2/23/13, that failed to evidence verbal orders for admission to home care until 1/16/13. This was evidenced by the following:</p> <p>a. A clinical document titled "Order" and dated 1/16/12 and signed by Employee P, Registered Nurse, stated, "Clarification for admission order for admission 12/26/12. New admit to home care for s / p [status / post], fall, pneumonia, uti [urinary tract infection], weakness, shingles, hospitalization 12/19 - 12 /21 per patient request admission 12/26/12 due to holiday SN [skilled nurse], PT / OT [physical therapy / occupational therapy]."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>b. The clinical record included visits for skilled nursing on 12/26/12, 12/28/12, 1/2/13, and 1/9/13; physical therapy on 12/27/12, 12/31/12, 1/2/13, 1/4/13, 1/8/13 and 1/11/13; and occupational therapy on 12/29/12.</p> <p>c. On 1/16/13 at 10:05 AM, the director of nursing indicated there were no orders present in the record to start care.</p> <p>4. Clinical record # 17, SOC 11/28/12, included a plan of care for the certification period of 11/28/12 - 1/26/13 that failed to evidence a verbal admission orders for care until 1/6/13. This was evidenced by the following:</p> <p>a. A clinical document titled "Home Health Certification and Plan of Care" with a certification period of 11/28/12 - 1/26/13 lacked a physician signature. The document included a signature and date of verbal start of care on 11/27/12 and a electronic signature by Employee X, Physical Therapist, on 12/7/12. There was no evidence that any other verbal orders were included in the record to start or initiate physical therapy visits until 1/6/13. Employee X made a visit for a start of care assessment on 11/28/12 and other visits on 11/29/12, 12/4/12, 12/6/12, 12/11/12, 12/13/12, 12/15/12, 12/18/12,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>12/20/12, 12/22/12, and 12/27/12.</p> <p>b. On 1/16/13 at 1:25 PM, Employee A, the director of nursing, indicated that there were no signed physician orders in this record and the physician was out of the office at this time. The physical therapist had failed to obtain any signed orders for care until 1/6/13.</p> <p>5. The agency policy titled "Plan of Treatment / Care" with an effective date of 6/99 and review date of 6/11 stated, "Medical care shall follow a written plan of care established and periodically reviewed by the physician."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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
N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on home visit observation, clinical record review, interview, and policy review, the agency failed to ensure the plans of care included all the required elements for 3 of 20 records reviewed (#3, #12, #17) creating the potential for omission of care that could affect all of the patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC)</p>	N0524	<p>N 524 Educators will develop and conduct mandatory education for skilled staff regarding admission assessments, admission orders and the Plan of Care by 2/15/13. To prevent reoccurrence, Start of Care documentation will be reviewed by Case Coordinator and will be concurrently monitored by QI Coordinator as of 2/15/2013. See attached.</p>	02/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>12/22/12, included a plan of care (POC) for the certification period 12/22/12 - 2/19/13. This POC failed to include the patient's left arm arteriovenous (AV) fistula for hemodialysis treatment, that was observed at a home visit, and the care and safety precautions that should be present on the POC.</p> <p>a. On 1/10/13 at 1:15 PM, patient #3 was observed to have a left arm AV fistula.</p> <p>b. Communication notes on 1/4/13 indicated the patient received hemodialysis at DaVita.</p> <p>c. On 1/14/13 at 4:20 PM, Employee Y, Registered Nurse, indicated the patient did have a AV fistula prior to SOC and there was no mention of the fistula in the clinical record or the care needed for this patient receiving hemodialysis.</p> <p>2. Clinical record #12, SOC 10/22/12, included a POC for the certification period of 10/22/12 - 12/20/12 that failed to evidence a timely physician's signature. This was evidenced by the following;</p> <p>a. The POC included a physician signature from 12/13/12.</p> <p>b. On 1/14/13 at 4:45 PM, Employee</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
(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>S, the alternate director of nursing, indicated the physician's signature was late.</p> <p>3. Clinical record # 17, SOC 11/28/12, included a plan of care for the certification period of 11/28/12 - 1/26/13 that failed to evidence physician's signature. This was evidenced by the following:</p> <p style="padding-left: 40px;">a. A clinical document titled "Home Health Certification and Plan of care" with a certification period of 11/28/12 - 1/26/13 lacked a physician signature. The document included a signature and date of verbal start of care on 11/27/12 and an electronic signature by Employee X on 12/7/12.</p> <p style="padding-left: 40px;">b. On 1/16/13 at 1:25 PM, Employee A, the director of nursing, indicated the POC failed to have a doctor's signature.</p> <p>4. The agency policy titled "Plan of Treatment / Care" with an effective date of 6/99 and review date of 6/11 stated, "The medical plan of care shall be developed in consultation with the home health agency staff and shall cover all pertinent diagnosis ... once the plan of care is completed, it is completed, it is sent to the physicians who will review, sign, date and return within 30 days."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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			
N0540	<p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit.</p> <p>Based on home visit observation, clinical record review, interview, and policy review, the agency failed to ensure the initial assessment completed by the registered nurse was complete and accurate for 1 of 10 clinical records reviewed (#3) of patients with home visit observations with the potential to affect all of the patients of the agency.</p> <p>Findings</p> <p>1. On 1/10/13 at 1:15 PM, patient #3 was observed to have a left arm AV fistula. Communication notes on 1/4/13 indicated the patient received hemodialysis at DaVita.</p> <p>a. Clinical record #3 included the initial assessment completed by Employee P, Registered Nurse, on 12/22/12 that failed to include the AV fistula noted in finding #1.</p> <p>b. On 1/14/13 at 4:20 PM, Employee Y, Registered Nurse, indicated the patient</p>	N0540	<p>N 540 Educators will develop and conduct mandatory education for skilled staff regarding admission assessments, admission orders and the Plan of Care by 2/15/2013. Comprehension will be verified by written test and ongoing during clinical record review and supervisory visits. To prevent reoccurrence, Start of Care documentation will be reviewed by Case Coordinator and will be concurrently monitored by QI Coordinator as of 2/15/2013. See attached.</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>did have a AV fistula prior to start of care and there was no mention of the fistula in the initial assessment.</p> <p>2. The agency policy titled "Admission Process and Comprehensive Admission Assessment" with an effective date of 6/99 and a revised date of 10/03 stated, "C. During the initial assessment, the admitting professional evaluates the patient and situation, using the admission criteria ... II. Purpose ... B. To assess the patient's physical, restorative, psychological, and social needs. C. To collect baseline data about the patient's condition."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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
N0553	<p>410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies.</p> <p>Based on clinical record review, policy review, home visit observation, and interview, the agency failed to ensure 1 of 1 licensed practical nurse (Employee D) observed at a home visit furnished service in accordance with agency policy with the potential to affect all patients with licensed practical nurse services.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC)1/14/13, included a plan of care (POC) with a certification period of 1/4/13 - 3/4/13, that failed to evidence the licensed practical nurse (LPN) furnished services in accordance with agency policy including setting the nursing bag on the floor, not cleaning equipment as required, not following the POC, using normal saline that had not been labeled correctly, and discarding waste from a dressing change on the floor. This was evidenced by the following:</p> <p>a. On 1/10/13 at 9:20 AM, Employee</p>	N0553	N 553 Home health educators will conduct education of all staff by 2/15/2013, focused on agency policies and standards of care. To prevent reoccurrence, practice in accordance with these policies will be evaluated on an ongoing basis, during supervised visits and case conference. See attached.	02/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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>D, LPN, was observed to change a wound dressing on patient's second left toe that had been partially amputated. When Employee D entered the home, she was observed to place her nursing bag on the floor near patient #1. There was no barrier observed beneath this bag. Employee D took the patient's blood pressure with a blood pressure cuff and stethoscope. She placed the blood pressure cuff and the stethoscope on the floor after use. Before cleansing the patient's wound, Employee D opened a bottle of already opened normal saline, wrote on the bottle of normal saline, and cleansed the wound by pouring normal saline from this bottle onto a 4 X 4 gauze pad. This bottle had no initials noted for who had opened the bottle and was dated either 1/3/13 or 1/7/13. Employee D squeezed out neosporin ointment onto a clean 4 X 4 gauze pad and applied this to the second toe of the left foot wound. Employee D discarded the dirty wound dressing and other waste from performing the wound dressing change onto the floor of the patient's home without placing it into a garbage bag or rolled into newspaper.</p> <p>b. The POC failed to evidence an order to cleans the wound with normal saline as the LPN had done in the above home visit observation.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307			
(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>c. On 1/10/13 at 4:05 PM, the director of nursing indicated LPN had not followed agency policies.</p> <p>2. The agency policy titled "Infection Control: Handling Wastes and disposables" with an effective date of 10/1/08 stated, "B. Perform removal of bandages ... C. Wrap dressing soiled with blood or body fluid items in a plastic or paper bag, or roll them up in newspaper."</p> <p>3. The agency policy titled "Infection Control: Nursing Bag Technique" with an effective date of 10/1/08 stated, "In the home, identify a clean and safe area ... to set the bag ... Never set the bag on the floor ... before re - packing the nursing bag clean any reusable equipment with soap and water, alcohol wipes, or program approved disinfectant."</p> <p>8. The agency policy titled "Infection Control: Equipment Cleaning" with an effective date of 12/27/12 stated, "Don nonsterile gloves to protect hands from disinfectants ... stethoscope: routinely clean the bell diaphragm of the stethoscope with a disinfectant spray ... if disinfection of contaminated equipment is not possible in the patient's home, seal in a impermeable plastic trash bag and transport to the home health agency for</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN HOME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
---	---

(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>disinfection. Never place soiled or contaminated equipment in the nursing bag."</p> <p>9. The agency policy titled "Infection Control: Wound care and dressing changes" with an effective date of 10/1/08 stated, "Verify the physician's order for wound care. Gather all the supplies required for the dressing change, such as dressings, tape, scissors, specific treatment items and a disposal bag, and place in a clean area near the patient ... Remove the present dressing by lifting gently, touching only the top part of the clean corner ... discard the contaminated dressing into a disposal bag or wrap in newspaper ... remove and discard gloves and wash hands ... Unwrap the new dressing carefully. Apply a new pair of sterile or nonsterile gloves ... perform the wound care procedure according to the plan of care."</p> <p>10. The agency policy titled "Infection Control: Bag Technique" with no effective date stated, "Once in the patient's home, select the cleanest and most convenient work area and spread the newspaper. Place the bag on the newspaper."</p>			