STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157179	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME HEALTH AND HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 438 S EMERSON AVE GREENWOOD, IN46143	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	This was a revisit for the federal recertification survey completed on 12-6-11. Survey Date: 1-18-12 Facility #: 005346 Medicaid Vendor #: 100264890A Surveyor: Vicki Harmon, RN, PHNS St. Francis Home Health and Hospice is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 12-6-11 due to being found out of compliance with the Condition of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision. One Condition of Participation and six standard level deficienies were found corrected during this survey. Two standard level deficiencies were recited. Quality Review: Joyce Elder, MSN, BSN, RN January 20, 2012	G0000		
G0158	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on clinical record review and interview, the agency failed to ensure treatments had been completed in accordance with physician orders in 2 (#s 22 and 23) of 4 records reviewed creating the potential to affect all of the agency's 134 current patients. The findings include: 1. Clinical record number 22 included a plan of care established by the physician for the certification period 01-05-12 to 03-04-12 for dressing changes to the proximal and distal left lower extremity. The plan of care states, "Cleanse with NS [normal saline], Santyl to wound bed, Calazime to periwound, apply NS moistened gauze and cover with dry gauze. Secure with Kerlix." The record included a skilled nurse (SN) visit note dated 1-14-12 that failed to evidence the nurse, employee O, had applied Calazime to the periwound area and had applied NS moistened gauze. 2. Clinical record number 23 included SN visit notes, dated 1-4-12 and 1-5-12, that evidenced the SN, employee L, had packed the left elbow wound with Intrasite Gel. The record failed to include an order for the Intrasite Gel.	G0158	The Clinical Manager will re -educate the nursing direct care staff that prior to seeing a patient, they will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has followed the plan of care and interim orders and provided visits, procedures, and treatments accordingly. Remediation will be required for the staff who are identified as being deficient.The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	02/16/2012

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	3. The administrator, employee A, and the supervising nurse, employee B, were unable to provide any additional documentation and/or information when asked on 1-18-12 at 1:35 PM.			
G0170	The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review and interview, the registered nurse failed to ensure treatments had been completed in accordance with physician orders in 2 (#s 22 and 23) of 4 records reviewed creating the potential to affect all of the agency's 134 current patients. The findings include: 1. Clinical record number 22 included a plan of care established by the physician for the certification period 01-05-12 to 03-04-12 for dressing changes to the proximal and distal left lower extremity. The plan of care states, "Cleanse with NS [normal saline], Santyl to wound bed, Calazime to periwound, apply NS moistened gauze and cover with dry gauze. Secure with Kerlix." The record included a skilled nurse (SN) visit note dated 1-14-12 that failed to evidence the nurse, employee O, had	G0170	The Clinical Manager will re-educate the nursing field staff that prior to seeing a patient, they will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has followed the plan of care and interim orders and provided visits, procedures, and treatments accordingly. Remediation will be required for the staff who are identified as being deficient.The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	02/16/2012

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	applied Calazime to the periwound area and had applied NS moistened gauze. 2. Clinical record number 23 included SN visit notes, dated 1-4-12 and 1-5-12, that evidenced the SN, employee L, had packed the left elbow wound with Intrasite Gel. The record failed to include an order for the Intrasite Gel. 3. The administrator, employee A, and the supervising nurse, employee B, were unable to provide any additional documentation and/or information when asked on 1-18-12 at 1:35 PM.			
N0522	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 and interview, the agency failed to ensure treatments had been completed in accordance with physician orders in 2 (#s 22 and 23) of 4 records reviewed creating the potential to affect all of the agency's 134 current patients. The findings include: 1. Clinical record number 22 included a plan of care established by the physician	N0522	The Clinical Manager will re-educate the nursing field staff that prior to seeing a patient, they will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has followed the plan of care and interim orders and provided visits, procedures, and treatments accordingly. Remediation will be required for the staff who are	02/16/2012

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	for the certification period 01-05-12 to 03-04-12 for dressing changes to the proximal and distal left lower extremity. The plan of care states, "Cleanse with NS [normal saline], Santyl to wound bed, Calazime to periwound, apply NS moistened gauze and cover with dry gauze. Secure with Kerlix." The record included a skilled nurse (SN) visit note dated 1-14-12 that failed to evidence the nurse, employee O, had applied Calazime to the periwound area and had applied NS moistened gauze. 2. Clinical record number 23 included SN visit notes, dated 1-4-12 and 1-5-12, that evidenced the SN, employee L, had packed the left elbow wound with Intrasite Gel. The record failed to include an order for the Intrasite Gel. 3. The administrator, employee A, and the supervising nurse, employee B, were unable to provide any additional documentation and/or information when asked on 1-18-12 at 1:35 PM.		identified as being deficient.The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	
N0537	Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:			

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	Based on clinical record review and interview, the registered nurse failed to ensure treatments had been completed in accordance with physician orders in 2 (#s 22 and 23) of 4 records reviewed creating the potential to affect all of the agency's 134 current patients. The findings include: 1. Clinical record number 22 included a plan of care established by the physician for the certification period 01-05-12 to 03-04-12 for dressing changes to the proximal and distal left lower extremity. The plan of care states, "Cleanse with NS [normal saline], Santyl to wound bed, Calazime to periwound, apply NS moistened gauze and cover with dry gauze. Secure with Kerlix." The record included a skilled nurse (SN) visit note dated 1-14-12 that failed to evidence the nurse, employee O, had applied Calazime to the periwound area and had applied NS moistened gauze. 2. Clinical record number 23 included SN visit notes, dated 1-4-12 and 1-5-12, that evidenced the SN, employee L, had packed the left elbow wound with Intrasite Gel. The record failed to include an order for the Intrasite Gel.	N0537	The Clinical Manager will re-educate the nursing field staff that prior to seeing a patient, they will review and follow the written plan of care and / or interim orders and provide visits, procedures, and treatments accordingly. 10% of all clinical records will be audited quarterly for evidence that the clinical staff has followed the plan of care and interim orders and provided visits, procedures, and treatments accordingly. Remediation will be required for the staff who are identified as being deficient.The Director of Home Health Care Services will be responsible for monitoring these corrective actions to ensure that the deficiencies are corrected and will not recur.	02/16/2012

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	3. The administrator, employee A, and the supervising nurse, employee B, were unable to provide any additional documentation and/or information when asked on 1-18-12 at 1:35 PM.			