STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300051837	A. BUILDING B. WING	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOME HEALTH SERVICES INC	7895 BROADWAY AVENUE, SUITE G-A, MERRILLVILLE , IN, 46410

(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
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health for American Home Health Services, and was found to be in compliance in accordance with 42 CFR 484.102. Survey Dates: 3/29/22, 3/30/22, and 3/31/22 Facility ID: 003070	E0000		2022-04-26
N0000	Initial Comments This was a re-licensure survey in conjunction with a federal post condition revisit survey, conducted by the Indiana Department of Health Survey Dates: 3/29/22, 3/30/22, and 3/31/22 Facility: #003070	N0000		2022-04-26
G0000	This was a post condition revisit survey for American Home Health Services conducted by the Indiana Department of Health. Survey Dates: 3/29/22, 3/30/22, and 3/31/22 Facility ID: 003070 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer	G0000		2022-04-26

	to state form for additional state findings. American Home Health Services is precluded from providing its own home health aide training and competency evaluation for a period of two years from 2/15/22 2/18/22, due to being found out of compliance with Conditions of Participation 42 CFR 484.60 Infection Control. During this survey, Conditions of Participation 42 CFR 484.60 Infection Control was found to be in compliance and 16 standard citations were found to be corrected. Quality Review Completed 04/06/2022			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the home health agency failed to ensure the medication profile was reviewed as needed for 1 of 2 patients where a home visit was conducted. (#1) The findings include: Record review of an undated agency policy titled Medication Profile retrieved on 3/31/22, stated Policy The registered Nurse or Therapist will complete a medication profile for each client at the time of admission. The medication profile shall include all prescription and nonprescription including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the client is taking & Purpose To provide a complete list of all medications the client is taking and an evaluation of the client s knowledge of the medications the effects of these medications & To provide documentation of changes in the medication	G0536	The Governing Body immediately held an emergency meeting on 03-31-2022 at5:00 pm to address the initial results of the survey conducted by the IndianaState Department of Health (ISDH), and developed a plan of action that was immediatelyimplemented to ensure provision of a safe and quality care to all patients ofAmerican Home Health Services, Inc. During the meeting, the policy pertainingto the Medication Profile and Patient's Rights and Responsibilities werereviewed, as well as all charts of patients that were checked by the Surveyor. CornStarch that was prescribed noted during 03-24-2022 visit by SN was added to themedication list together with two (2) other medications ***(Exhibit 1)***,and once entered in the electronic medical record (EMR) became a part of themedication profile ***(Exhibit 2)*** as an addendum to the patient485/Plan of care of Patient #1, same Medication list print out ***(Exhibit 3)***provided to patient's home folder that was reviewed by the Surveyorduring the survey visit with the Home Health Aide (E) on 03-30-2022. Whenprinting medication list from the EMR, you have to select from the followingchoices ***(Exhibit 4)***: (1) Select All Drug Entry ***(Exhibit 5)***if you need a medication list from the 1st day of the episode tocurrent time; (2) Mid- episode Drug Entry ***(Exhibit 5)*** if you needmedication list from start of episode to mid episode; (3) Original 485medications ***(Exhibit 6)*** if you need medication list during thestart or 1st day of the episode; (4) Resumption of Care if you needa medication list during the date of the resumption of care; and (5) VerbalOrder ***(Exhibit 7)*** if you need a medication list that were addedthru a verbal order as an addendum to the plan of care. Regarding the new OTCmedication, Vaseline, which was used for	2022-04-26

	regime as they happen, and support changes needed to the plan of treatment & Special Instructions & 2. The Nurse/Therapist shall record on the Medication Profile all prescribed and over-the-counter (OTC) medications the client is currently taking & 12. Medication profiles created through electronic point of care documentation systems will have a copy in the client record and client s home if the agency is set up or managing the medication administration &. Record review of the agency s home folder on 2/15/2022, evidenced an agency document titled Patient s Rights and Responsibilities which stated All patients and patients representatives of American Home Health Services, Inc. have the right to be informed in advance of the services provided by the Agency and their responsibilities related to home health services. All information shall be provided in a manner understandable to the person & A. Patient s Rights: As a part of American Home Health Services, you have the right to: 1. Be fully informed in advance about the care and treatment to be furnished including the skilled staff that will furnish the care and the proposed number of visits they will make to your home &. An observation of a home visit was conducted on 3/30/2022, at 8:56 AM, for patient #1, start of care 3/4/2022, with home health aide (HHA) E, accompanied by administrator A, and clinical manager B. At 9:26 AM, HHA E applied Vaseline (petroleum jelly; used as a skin barrier to lock in moisture for dry skin and minor wounds) to the patient s feet. At 9:34 AM, HHA E applied cornstarch (Usually used as a thickening agent for cooking/baking; Can be used as a moisture absorbing powder on skin) to the patient s neck, under arms, and abdominal folds. At 9:43 AM, the patient s home folder was reviewed for required information, including but not limited to a medications list with instructions. Review of the home folder evidenced a medication profile with 34 prescribed and OTC medications. Review of the medication list evidenced corn starch was listed as a current medication with instructions. Review of the medication list failed to evidence Vaseline		the first time by the HHA (E) duringthe survey visit, it was reported by the HHAide (E) to RN on 03-30-2022. It wasnoted by the visiting RN on 04-01-2022 during the visit ***(Exhibit 8)*** toinclude it on the EMR ***(Exhibit 9)*** to update the medication list inthe form of a verbal order ***(Exhibit 10)*** sent to physician forapproval and signature, then attached to EMR as an addendum to the plan oftreatment. The home folder was updated as well by the visiting RN ***(Exhibit11)***. On 04-04-2022, an In-Service was conducted by the ClinicalSupervisor and the Administrator regarding the Policies and Procedures pertainingto the Medication Profile and Patient's Rights and Responsibilities ***(Exhibit12)*** were discussed with emphasis on need to perform medicationreconciliation every visit, to update the EMR and the Patient's medication listin the home folder for any new medications and/or any medication changes ofpatient to include all prescribed medications, all PRN medications, and all OTCmedications. To ensure compliance, the customer service of MyGenesys wascontacted by the Clinical Supervisor on 03-31-2022, and spoke with thedeveloper of the software, regarding the revision of the SN visit note page 2of the form to include **"Medication Changes "and two (2) separate check boxesto indicate medication changes were update both on EMR and Home folder**. Thedeveloper stated it will take time, but they will try to modify the form asrequested. On 04-25-2022, modification was completed by the developer and readyfor use anytime. The new revised SN visit note was presented by the ClinicalSupervisor to the Governing Body for review which merited approval. Notificationto all SN was immediately disseminated on 04-26-2022 that effective 05-01-2022,the old SN visit note shall be replaced by the newly revised SN visit note ***(Exhibit13)*** which will be available for use for all active patients, andinstructions as to how to fill out the new section was provided by the ClinicalSupervisor. It will be the responsibility of the Quality Assurance Supervisorto ensure 100 % compliance utilizing the newly revised Clinical Chart Reviewaudit tool ***(Exhibit 14)*** to make sure medication profiles both inEMR and home folder of all active patients are updated by the visiting RN in atimely manner.	

	was listed with instructions on the medication list. Observation failed to evidence all medications including topical ointments were added to the medication list with instructions for use. On 3/29/2022, at 2:35 PM, the current plan of care, medication list, and home health aide care plan were requested. At 3:14 PM, clinical manager B submitted the requested items, including a document titled Medication Profile. This document evidenced instructions for 30 medications, including but not limited to oral medications, eye drops, medicated powders, and topical ointments. Review of this document failed to evidence cornstarch powder and Vaseline topical ointment were listed with instructions. Record review failed to evidence a review of all medications and OTC ointments and powders were completed by the skilled nurse per the agency policy. During an interview on 3/31/2022, when queried what Vaseline was being used for, clinical manager B indicated the topical ointment was new and the RN (registered nurse) was informed to add to the medication list. The clinical manager also queried if all lotions and creams should be added to the medication list. 17-14-1(a)(1)(B)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations;	G0574	The Governing Body immediately held an emergency meeting on 03-31-2022at 5:00 pm to address the initial results of the survey conducted by theIndiana State Department of Health (ISDH), and developed a plan of action thatwas immediately implemented to ensure provision of a safe and quality care toall patients of American Home Health Services, Inc. During the meeting, thepolicy pertaining to the Plan of Treatment and Medication Profile were reviewedby the Governing Body, as well as all charts of active patients that were examinedby the Surveyor. On 03-31-2022, chart review of Patient #1, the medication list***(Exhibit 15)*** provided to patient home and on EMR contained theright instructions as to when to hold the Midodrine Hydrochloride (to treat lowblood pressure) which is to hold if systolic BP is over 160 mmHg; and includedthe right instructions as to when to hold the Lisinopril (to treat high bloodpressure) which is to hold if systolic BP is lower than 130 mmHg. The 485 was updatedto	2022-04-01

	(viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure the plan of care was individualized for all treatments, including but not limited to medications for 1 of 2 active clinical records reviewed. (#1) The findings include: Record review of an agency document titled Plan of Treatment retrieved on 3/31/2022, stated Policy Home care services are furnished under the supervision and direction of the client s physician & Purpose To provide guidelines for agency staff to develop a plan of treatment individualized to meet specific identified needs & Special instructions & 2. The Plan of treatment shall be completed in full to include: & l. Medications, treatments, and procedures & o. Instructions to client/caregiver, as applicable & 11. The PRN (as needed) orders will be accompanied by a description of the client s needs that could warrant a visit &. Record review of an undated agency policy titled Medication Profile retrieved on 3/31/22, stated Policy The registered Nurse or Therapist will complete a medication profile for each client at the time of admission. The medication profile shall include all prescription and nonprescription including regularly scheduled medications		capture the proper use of the midodrine HCL and Lisinopril, and a copy ofthe updated Plan of care was provided to the Surveyor before she left, and atthe same time a copy was resent to MD for approval and signature indicating reasonwhy it was resent back to supersede the previous plan of care that was signedby physician on 03-22-2022. The revised 485 was approved and signed by the physicianon 04-03-2022 ***(Exhibit 16)***. In-service conducted by the ClinicalSupervisor and the Administrator on 04-04-2022 ***(Exhibit 17)*** includedthe Policies and Procedures on Plan of Treatment and Medication Profileemphasizing on importance of completeness and correctness of the 485s/ Plans ofCare. To ensure compliance, the Governing Body approved the revision of theClinical Chart Review audit tool to include ***Item B (1)*** **485/ POCproofread-complete/correct prior to MD approval / sign.** It will be theresponsibility of the Quality Assurance Supervisor to ensure 100 % complianceand warrant all 485s/ Plans of Care for all active patients be proofread priorto sending to physician for approval and signature utilizing the revised ClinicalChart Review audit tool ***(Exhibit 18)*** revised and approved on03-31-2022 for immediate implementation.	

The profile will be reviewed and updated as needed to reflect current medications the client is taking & Purpose To provide a complete list of all medications the client is taking and an evaluation of the client s knowledge of the medications the effects of these medications & To provide documentation of changes in the medication regime as they happen, and support changes needed to the plan of treatment & Special Instructions & 3. The Medication Profile shall document: & e. Route and frequency of administration & f. Contraindications or special precautions &.

Clinical record review on 3/31/2022, for patient #1, start of care 3/4/2022, pertinent diagnosis including but not limited to hypertension (high blood pressure), evidenced an agency document titled Home Health Certification and Plan of Treatment for certification period 3/4/2022 5/2/2022, which was signed by the physician on 3/22/2022. This document had an area subtitled 10. Medications: Dose/Frequency/Route that stated & Midodrine Hydrochloride [used to treat low blood pressure] Hold if systolic BP [top number of blood pressure] is over 160 & 5 MG [milligrams]- Three times a day as needed & Another area subtitled 21. Orders for Discipline and Treatments: & Teach regarding importance of monitoring BP [blood pressure] 3X [three times] a day & Education & management of & Lisinopril [anti-hypertensive medication; used to lower blood pressure] to use if systolic BP is over 160 MMHG [millimeters of mercury; measurement used to assess blood pressure], Midodrine to hold if systolic BP is over 130 MMHG &. Review of the plan of care failed to evidence clear and concise directions for Midodrine. Review of this document failed to evidence the PRN indications contained individualized instructions for the patient.

During an interview on 3/31/2022, at 1:10 PM, clinical manager B indicated Midodrine was supposed to be used to increase the patient s blood pressure if it was low. She indicated the document that stated the patient should hold the medication if the systolic blood pressure was greater than 160 was a typo. Clinical manager B stated We know

	Lisinopril is used for hypertension [high blood pressure], and Midodrine is used for hypotension [low blood pressure]. 410 IAC 17-13-1(a)(1)(D)(i-xiii)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review, and interview, the home health agency failed to ensure the home health aide followed the care plan as instructed by the registered nurse for 2 of 2 patient records reviewed with a home health aide, from a total of 4 clinical records reviewed. The findings include: 1. Record review of an undated agency policy titled Home Health Aide Services retrieved on 3/31/2022, stated Policy Home Health Aide [HHA] services will be provided to appropriate clients on an intermittent, part-time or full-time basis, under the direct supervision of an agency Registered Nurse/Therapist in accordance with a medically approved Plan of Treatment & Purpose To abide by state/federal guidelines to the agency staff, physicians, and community for the appropriate utilization of Home Health Aide services & Special Instruction 1. Home Health Aide services may include: a. Providing personal care services including bathing, dressing, feeding, weighing, backrubs, skin care and shampoos as directed by the treatment plan and licensed professional & 3. The Aide will follow the treatment plan and will not initiate new services or discontinue services without contacting the supervising Nurse/therapist & 8. All services provided by the Home Health Aide shall be documented in the clinical	G0800	The Governing Body immediately held an emergency meeting on 03-31-2022at 5:00 pm to address the initial results of the survey conducted by theIndiana State Department of Health (ISDH), and developed a plan of action thatwas immediately implemented to ensure provision of a safe and quality care toall patients of American Home Health Services, Inc. During the meeting, thepolicy pertaining to the Home Health Aide Services and Home Health Aide:Documentation were reviewed, as well as all charts of patients provided withHome Health Aide services that were checked by the Surveyor. On 04-04-2022, an In-servicewas conducted by the Clinical Supervisor and the Administrator regarding thesepolicies and Procedures on Home Health Aide Services and Home Health Aide:Documentation ***(Exhibit 19)*** with emphasis on preciseness whendeveloping the Home Health Aide Care Plan to ensure all patient's needs areproperly addressed and all tasks completed are properly documented. ClinicalSupervisor further discussed that it is necessary for a Home Health Aide Care Planto be updated by the visiting RN every time a change is required by completinga new Home Health Aide Care Plan to make it current. To ensure compliance, thecustomer service of MyGenesys was contacted by the Clinical Supervisor on 03-31-2022,and spoke with the developer of the software, requested the Home Health AideCare Plan be revised to indicate ***"Mouth Care"*** with a check box tobe performed by the Home Health Aide ***"per request"*** depending onthe time of the visit as most patients would like mouth care/ oral hygiene becompleted immediately after meals. The developer stated it will take time, butthey will try to modify the form as requested. On 04-25-2022, modification wascompleted by the developer and is ready for use. The newly revised Home HealthCare Plan was presented to the Governing Body for review which was immediatelyapproved. On 04-26-2022, a notification to all visiting SN was immediatelydisseminated that the Home Health Aide Care Plan form ***(Exhibit 20)*** wasrevised and that the newly revised form shall be used by the visiting RN forall active patients effective immediately, (04-26-2022). The ClinicalSupervisor provided instructions regarding the change and how to fill it out inEMR ***(Exhibit 21)***. The Clinical Chart Review audit tool wasrevised as well to include ***Item G- 1. Completed & e-signed by SN- HHACare Plan-***	2022-04-26

	record &. 2. Record review of an undated agency policy titled Home Health Aide: Documentation stated Policy Home health aides will document care/services provided on the home health aide charting form. Care/services provided should be in accordance with direction provided in the Home Health Aide Treatment plan & Purpose To provide documentation of the care performed by the Home Health Aide on each visit & Special Instructions 1. The Home Health Aide shall utilize the appropriate Home Health Aide flow sheet or charting form to document services rendered to the patient &. 3. Clinical record review on 3/31/2022, for patient #1, start of care 3/4/2022, primary diagnosis of Type 2 diabetes with diabetic neuropathy (pain, weakness, and numbness from damaged nerves), evidenced an untitled agency document that was electronically signed by clinical manager B on 3/4/2022. This document indicated HHA E was the assigned for patient #1, and stated Check all the [sic] apply: Change to this care plan requires completion of another HH [home health] aide plan & This document had tasks including but not limited to sponge bath, mouth care, and skin care were assigned. Record review evidenced an agency document titled Home Health Aide Note from 3/28/2022, which was electronically signed by HHA E. This document had an area subtitled Home Health Aide Checklist with Intervention that stated & Oral Hygiene &. Review of this document failed to evidence oral hygiene was selected to indicate the task was completed. Record review failed to evidence the HHA care plan was followed as instructed by the skilled nurse. 4. Clinical record review on 3/31/2022, for patient #4, start of care 4/23/2021, primary diagnosis of chronic obstructive pulmonary disorder (COPD; a condition that involves constriction of the airways and difficulty or discomfort breathing), evidenced an untitled agency document which was electronically signed by alternate clinical manager C on		***revised 4-26-22*** which was immediately approved by theGoverning Body. It will be the responsibility of the Quality AssuranceSupervisor to ensure 100 % compliance utilizing the newly revised ClinicalChart Review audit tool ***(Exhibit 22)*** to make sure that the HomeHealth Aide Care Plan both in EMR and home folder of all active patients areupdated by the visiting RN in a timely manner.	

	G was assigned and stated Check all the [sic] apply: Change to this care plan requires completion of another HH [home health] aide plan & This document had tasks including but not limited to sponge bath, mouth care, and skin care were assigned. Record review evidenced agency documents titled Home Health Aide Note from 2/7/2022, 2/11/2022, and 2/14/2022, that were electronically signed by HHA G. These documents had an area subtitled Home Health Aide Checklist with Intervention that stated & Oral Hygiene &. Review of these documents failed to evidence oral hygiene was selected to indicate the task was completed. Record review failed to evidence the HHA care plan was followed as instructed by the skilled nurse. 5. During an interview on 3/31/2022, at 1:15 PM, clinical manager B indicated the HHA care plan should state the tasks can be completed per the patient s request. Clinical manager B indicated if oral care is on the care plan, the HHA should document it was completed.			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the home health agency failed to ensure all clinicians' documentation was clear and complete to provide an accurate description of the assessment for 1 of 2 closed records reviewed. (#3) The findings include: Record review of an undated agency policy titled Clinical Documentation retrieved on 3/31/2022, stated Policy AMERICAN HOME HEALTH SERVICES, INC., INC. [sic] will document each direct contact with the client. The documentation will be	G1024	The Governing Body immediately held an emergency meeting on 03-31-2022 at5:00 pm to address the initial results of the survey conducted by the IndianaState Department of Health (ISDH), and developed a plan of action that was immediatelyimplemented to ensure provision of a safe and quality care to all patients ofAmerican Home Health Services, Inc. During the meeting, the policy pertainingto the Clinical Documentation was reviewed, and as all charts of patients thatwere checked by the Surveyor. The Clinical Supervisor called the attention ofRN H to clarify his skilled notes for patient #3 regarding skin assessment and clarified that skin over upper and lowerextremities were dry, and body folds were moist. The Clinical Supervisor andthe Administrator conducted an In-service on 04-04-2022 ***(Exhibit 23)*** pertainingto the Clinical Documentation and the SN Visit Note highlighting on appropriateand accurate documentation of assessment and evaluation to properly picture thecurrent condition of the patient during actual SN visit. The ClinicalSupervisor revised the Clinical Chart Review Chart audit tool to include ***ItemF. Skilled Nursing 4. System Review Completed – expounded/ described accurately***as needed; presented to and approved by the	2022-04-26

	completed by the direct caregivers and monitored by the skilled professional responsible for managing client s care & Purpose To ensure that there is an accurate record of the services provided, client response, and ongoing need for care & Special Instructions 1. All skilled services provided by Nursing, Therapy, or Social Services will be documented in the clinical record & 3. Additional information that is pertinent to the client s care or condition may be documented on the Progress Note or Flow Sheet &. Record review of an undated agency policy titled Skilled Nursing Services retrieved on 3/31/2022, stated Policy Skilled nursing services will be provided by a Registered Nurse & in accordance with a medically approved Plan of treatment (physician s orders) & Special Instructions 1. The registered nurse: & g. Prepares clinical and progress notes & 3. Skilled nursing activities in the home care setting may include: observation and assessment, teaching and training activities. Management and evaluation of the treatment plan and routine and complex skilled procedures & 4. The nurse will demonstrate competency in providing procedures such as: & c. Documenting and implementing physician orders &. Clinical record review on 3/31/2022, for patient #3, start of care 8/5/2021, primary diagnosis of type 2 diabetes, evidenced an agency document titled Skilled Nursing Visit Note which was electronically signed by Registered Nurse (RN) H on 2/21/2022. This document had an area subtitled Skin in which boxes were checked to indicate the patient s skin was warm, moist, and dry. This area stated Skin intact, warm to touch; no open wounds or redness; noted +2 edema [swelling caused by excess fluid] on bilateral anklesand [sic] feet , instructed to protect from injury and maintain good skin care &. Record review evidenced an agency document titled Skilled Nursing Visit Note which was electronically signed by RN H on 2/28/2022. This document had an area subtitled Skin in which boxes were checked to indicate the patient s skin was warm,		Governing Body during themeeting on 03-31-2022; and which is directed for immediate implementation. Itshall be the responsibility of the Quality Assurance Supervisor to ensure 100%compliance utilizing the newly revised Clinical Chart Review audit tool ***(Exhibit24)*** to make sure that all active patients' current condition areproperly and accurately documented.	

	moist, and dry. This area stated, Skin warm to touch; 2+ edema bilateral ankle and foot &. Record review evidenced an agency document titled Skilled Nursing Visit Note which was electronically signed by RN H on 3/7/2022. This document had an area subtitled Skin in which boxes were checked to indicate the patient s skin was warm, moist, and dry. This area stated, No skin alterations, open wounds or redness &. Record review evidenced the patient s skin was assessed to be moist and dry, which required more explanation for. Record review failed to evidence comments or narrative about the patient s moist and/or dry skin as indicated in the agency s policy for pertinent information. Review evidenced contradictory descriptions of the patient s skin. Record review failed to evidence clear, concise, and accurate documentation of the skin assessment. During an interview on 3/31/2022, at 1:31 PM, clinical manager B indicated RN H probably referred to the patient s underarms and abdominal folds as moist, and dry for other areas. 410 IAC 17-15-1(a)(7)			

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 reverse for further 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.

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