

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157599	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER HEARTS WITH INTEGRITY			STREET ADDRESS, CITY, STATE, ZIP CODE 603 E NORTH STREET , HARTFORD CITY, Indiana, 47348	
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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: May 13, 14, 15, and 16. 2024 Active Census: 59 At this Emergency Preparedness survey, Hearts With Integrity was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: May 13, 14, 15, and 16, 2024 12-Month Unduplicated Skilled Admissions: 69 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR 5/21/24 by A2	G0000		
G0536	A review of all current medications CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the clinician completed a review of all medications the patient was taking for 3 of 3 patients with home observation visits	G0536		

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
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G0536	<p>Continued from page 1 (Patient #1, #2, and #3).</p> <p>Findings include:</p> <p>1. The Medication Reconciliation policy included but not limited to "At the time of admission to the home care agency, the admitting professional will document a complete list of medications taken by the client prior to admission. This will include all over the counter, prescribed, and PRN [as needed] medications. Documentation of these medications will be listed on the Medication profile and include name, dose, route of administration, frequency... The home care nurse should also review ALL medications in the home... By asking the client to bring you the bottles of all prescription and non-prescription medicines they take, you are initiating the process of getting the most accurate list... Medications will be reviewed with the client on each home visit to determine if other prescriptions or non-prescription drugs are being taken."</p> <p>2. The Comprehensive Client Assessment policy included but not limited to "A review of all medications including over the counter medications the client is taking in order to identify any potential adverse effects and drug reactions..."</p> <p>3. On 5/14/24 at 11:50 AM, RN 1 was observed providing care for Patient #1. RN 1 reviewed medication bottles with Patient #1's caregiver who administers Patient #1's medications. Observed medications including but not limited to Lansoprazole 30 milligrams (mg) capsule, a medication used to reduce the amount of acid the stomach makes; Mirbetriq (mirabegron) 50mg, a medication used to treat overactive bladder; and Metamucil 3-in-1 fiber supplement. Patient #1's caregiver relayed Patient #1 had been taking the Lansoprazole since it was filled on 4/16/24 and that it would be discontinued after the last dose on the following Wednesday. The caregiver also relayed Patient #1 had been taking the Mirbetriq for years and had been taking the Metamucil for a long time.</p> <p>Patient #1's clinical record included a medication list. The medication list failed to include Lansoprazole, Mirbetriq, and or Metamucil.</p> <p>On 5/14/24 at 1:24 PM, RN 1 relayed she usually asks for all medication bottles to compare to the medication list and speaks with whoever is in charge of the medications. RN 1 relayed she reviewed Patient #1's medication list with Patient #1's daughter who sets up the patient's medications.</p>	G0536		

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G0536	<p>Continued from page 2</p> <p>On 5/15/24 at 11:15 AM, the Administrator relayed Lansoprazole, Mirabegron, and Metamucil were not on the agency's medication list.</p> <p>4, On 5/15/24 at 1:34 PM, LPN 1 was observed providing care for Patient #2. LPN 1 reviewed medication bottles with Patient #2. Glipizide 10 mg, a medication used to treat high blood sugar levels in those with type 2 diabetes mellitus, to be taken twice daily, was observed in Patient #2's home. Patient #2 relayed they have been taking Glipizide 10 mg twice daily for 3 to 4 years.</p> <p>Patient #2's clinical record included a medication list which included but not limited to Glipizide 10 mg once a day. The medication list failed to include the correct frequency for Glipizide.</p> <p>On 5/15/24 at 2:02 PM, LPN 1 indicated she reconciles medications in the home by asking at every visit and going through medication bottles every 60 days.</p> <p>On 5/15/24 at 11:15 AM, the Administrator, who completed the initial comprehensive assessment for Patient #2, indicated the medication list says once per day and indicated that must have been an entry error.</p> <p>5. On 5/15/24 at 9:29 AM, PT 1 was observed providing care for Patient #3. Medication bottles were reviewed with Patient #3's spouse who indicated they manage Patient #3's medications. Celebrex 200 mg, a medication used to treat symptoms caused by arthritis, to be taken twice daily was observed in Patient #3's home. Patient #3's spouse relayed Patient #3 had been taking Celebrex 200 mg twice daily and Aspirin 81 mg twice daily since prior to admission to the home health agency.</p> <p>Patient #3's clinical record included a medication list. The medication list included but not limited to Celebrex 200 mg once a day and Aspirin 81 mg once a day. The medication list failed to include the correct frequency for Celebrex 200 mg and Aspirin 81 mg.</p> <p>On 5/14/24 at 10:14 AM, PT 1 indicated she asks if there any medication changes at each visit and that the nurse looks at medication bottles at admission.</p> <p>On 5/15/24 at 11:22 AM, the Administrator relayed the medication list indicated the Celebrex 200 mg and the Aspirin 81 mg were each to be taken once a day.</p> <p>6. On 5/15/24 at 11:09 AM, the Administrator relayed any medications the patient is taking should be included in the agency's medication list, including</p>	G0536		

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G0536	Continued from page 3 over-the-counter medications and supplements. The Administrator indicated clinicians should check medication bottles in the home against the medication list at admission and at recertifications. 17 IAC 17-14-1(a)(1)(B)	G0536		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure provider orders were received prior to services being provided for 2 of 5 active patient records reviewed (Patient #4 and #5). Findings include: 1. The Physician/ Non-physician Practitioner Orders policy included but not limited to "All medications, treatments, and services provided to clients must be ordered by a physician/allowed non-physician practitioner... All medications and treatments, that are part of the client's plan of care, must be ordered by the physician/allowed non-physician practitioner..." 2. Patient #4's clinical record included a plan of care (POC) for the certification period 4/25/24 to 6/23/24 that was returned to the agency with the provider's signature on 5/14/24. Patient #4's clinical record included skilled nursing (SN) notes indicating SN treatment including but not limited to wound care was provided for Patient #4 on 4/30/24, 5/02/24, 5/07/24, and 5/09/24. The clinical record failed to evidence a verbal or written order was obtained from the attending physician for the agency to provide services and treatments prior to 5/14/24. On 5/16/24 at 9:22 AM, the Clinical Manager relayed she completed the comprehensive assessment and POC for Patient #4. The Clinical Manager further relayed she had spoken with the wound care doctor's office regarding wound care orders but had not documented the time or the person spoken with for verbal orders and relayed she had left a message for the attending physician but had not received a call back with verbal orders for visit frequency. The Clinical Manager also relayed the POC had been returned signed by the attending physician on 5/14/24.	G0580		

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G0580	Continued from page 4 3. Patient #5's clinical record included a plan of care (POC) for the certification period 4/20/24 to 6/18/24 that was returned to the agency with the provider's signature on 4/30/24. Patient #4's clinical record included a SN note indicating SN treatment, including but not limited to an indwelling urinary catheter change, was provided for Patient #4 on 4/25/24 and included home health aide (HHA) visit notes indicating HHA care, including but not limited to a partial bath, was provided on 4/23/24 and 4/25/24. The clinical record failed to evidence a verbal or written order was obtained for the agency to provide services and treatments for the certification period 4/20/24 to 6/18/24 prior to 4/30/24. On 5/16/24 at 10:47 AM, RN 2 relayed that she typically leaves a voicemail for the provider regarding accepting the patient for SN services and letting them know the POC will be faxed for review and signature. RN 2 relayed she usually doesn't speak with anyone to get a verbal order. 4. During an interview on 5/16/24 at 9:15 AM, the Clinical Manager indicated documentation of verbal orders should include the doctor's name, who you spoke with, the date and time, and the orders. 410 IAC 17-13-1(a)	G0580		
G1030	Retrieval of records CFR(s): 484.110(e) Standard: Retrieval of clinical records. A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to evidence patients were informed of their right to receive a copy of their medical record at no charge at the time of the next home visit or within four business days, whichever is sooner, for 1 of 1 agency. Findings include: 1. The Client Privacy Rights policy included but not	G1030		

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G1030	<p>Continued from page 5 limited to "Clients receiving services from this agency have the right to access their protected health information for inspection or copying.</p> <p>2. The admission packet failed to include information about the right for patients to receive a copy of their medical records at no charge at the next home visit or within four business days, whichever is sooner.</p> <p>The admission packet included a Notice of Privacy Practices that included, but not limited to, "With a very few limited exceptions... you have the right to inspect and obtain a copy of medical information about you. To inspect or copy medical information about you, you must submit your request in writing. We will usually act on your request within thirty (30) calendar days after we receive your request." The admission packet included a Patient Rights and Responsibilities section which included but not limited to "The home health agency shall advise the patient or the patient's legal representative of its policies and procedures regarding the accessibility of clinical records."</p> <p>3. On 5/13/24 at 1:44 PM, the Administrator relayed the agency provided patients a copy of their clinical record upon request, usually the next day, and indicated she did not know where that information could be found in the admission packet.</p> <p>410 IAC 17-12-3(b)(3)</p>	G1030		