Iowa Center for Home Care
HHA Survey Review G-Tags
2nd Quarter 2020

Total # of reports: 9
Recertification surveys: 8 (0 deficiency free)
Complaint: 1 (0 deficiency free)
Extended: 0 (0 deficiency free)
Revisits: 1 (0 deficiency free)
Inability to competize = 1
Validation survey = 0

Old CMS description of G-tags

New G tags

G-Tags cited by Iowa Department of Inspections and Appeals

G414

- Patients were not provided with the contact information for the Administrator.

G510

- Failed to provide initial assessment of patient in the 48 hours after referral

G520

- Start of Care Assessment must be completed within 5 days of the Start of Care.

G528

- The patient's current health, psychosocial, functional and cognitive status were not assessed. Some assessments missing vitals signs, height and weight, wound assessments, DRR.

- No wound measurements; Initial POC stated continuous O2 but on recertification there was no documentation of 02. Incomplete wound measurements, lack depth of wound

G536

No DRR completed for 7 out of 16 clients sampled

- Duplicate meds were not identified on the DRR;
- Failure to perform the drug regimen review in a complete and accurate manner. RN failed to do a DRR on admission after setting up meds. POC lacked orders for a laxative that the patient said she was taking. POC lacked order for acetaminophen for which the patient stated was taking once a week. POC laced orders for 2 analgesics that patient reported using, DRR missing all 5 components. DRR not documented between 5-819 and 3-3-2020 on one patient.
- DRR did not address all 5 components in 4 of 7 charts reviewed.
- Failed to complete a full Drug Regiment Review-failed to meet all components. Patient resumed a medication that was expired - not listed as expired on DRR. Expired medications in home failed to list on DRR.

G546

- Recertification assessments were not completed within the last 5 days for 6 out of 8 patients sampled. Totally missing medication reviews and/or completed late.
- Agency failed to complete updates to the comprehensive assessments at recertification in the last five days of each 60 day period for one patient (recert oasis was not completed).
- Recertification - late outside of the 5 day window

G548

- Resumption of care outside of the 48 hour window. Out of compliance on timing of resumption

G550

- Discharge assessments not completed within 2 days. No recertification assessment or physician orders from 9/1 until 9/30 when the patient was discharged. Physician not notified of discharge.

G570

- CONDITION LEVEL: Failed to notify physician of inability to complete interventions G572). Failed to ensure staff completed an individualized Plan of Care that contained accurate information (G574). Failed to provide medications, treatments and services only as ordered by the physician (G584).

Failed to integrate orders for all physicians involved a patient's care (G604). Failed to provide written documentation of the name and contact information for the clinical manager (G622).

- Equipment not listed appropriately on POC; no code status on patient on POC; failed to have physician order for shaving and catheter care. Equipment not listed and dosages not listed, no reason for PRN needs.

G572

- Failed to notify physician of changes in visit frequency in 4 out of 6 patients. Physician was not notified of missed visits.
- Services not provided according to the POC and untimely physician notification (not same day) for missed visits.
- No missed visit note to physician

G574

- Plan of Care did not include accurate completion of all components required. Lacking accurate listing of equipment, medications, information related t any Advance Directives, interventions, and treatments.
- Oxygen lacked mode used to administer; an oral med lacked how much "one dose" was; Med lacked strength of "one tablet" .DME missing on 485: BP cuff, gait belt, incontinent supplies, bed alarm, long handed sponge and included a sock aid which patient was not using.
- The POC failed to include PT interventions that were included on the PT evaluation; not all DME on POC(1/2 side rail); the POC did not have orders for correct doses of several medications; meds in found in home had expired dates on them; therapy notes documented use of tracheostomy and ventilator, gastrostomy supplies and reverse walker but these were not identified on the 485 in DME
- Agency failed to ensure the accurate completion of all components compromising the POC including all supplies and an accurate list of the patient's current medications. POC did not identify: scale, bp machine, cane, shower chair, med planner, disposable incontinency pads. An order for A&D ointment failed to specify where the patient should apply ointment. POC identified Cod liver oil 1 tab daily but did not identify the dosage. POC specified Dilitiazem 180 mg every morning but on observation of RN setting up meds surveyor identified that the dose was 120 mg every morning - RN stated that the dose was wrong on the POC.
- Patient #3: had an emergency response system in the home which was not on the POC. Patient # 7 had compression stockings and incontinence pads in the home which were not on the POC. Patient #4 had orders for Lactulose but POC did not specify the correct route of the medication. Patient #5 had an order for Gabapentin 1-2 capsules at bedtime but did not specify a dose. Patient #2 POC did not has incontinence supplies as equipment on the POC. Patient #2 had OT frequency written as "as needed for four weeks" plan failed to specify a specific frequency.
- Patient stated had a cane and used occasionally. Not listed on POC

G576

- POC lacked orders for Vitamin D3; lacked orders for Vitamin B; lacked orders for Digoxin; No POC update when client had new meds added; "working POC" not updated
- The clinical record lacked documentation of an updated POC with the interim physician orders for the certification period. The revised HH POC update included the new frequency orders for ST, PT, and OT but failed to include the goals and interventions for the therapies.
- All order, including VO's must be recorded in the POC. Agency reported the POC is not updated with physician VO's or any other changes until the end of each cert period as the nurses can see the VO's in another section of the EMR. Agency reported that an update to the POC is not created in the EMR unless the RN clicks on a specific tab in the system to create the update.
- All orders recorded on POC: agency failed to update the POC with all new physician orders for 5 of 7 patient with interim orders.
- POC had old orders from prior POC.

G580

- Staff did not obtain physician orders for provision of services. Did not complete every 4 hour assessments as ordered.
- Drugs, services, treatments are provided only as ordered by a physician. Accepted wound care orders from an ARNP that contradicted physician orders. Nurse ordered a patient with low blood pressure to take extra salt and hold BP medication without a physician order. Did not call the physician until the next day. No dressing change orders for treatment performed. Nurse did not perform diabetic foot care as ordered. Nurse did not check INR as ordered. Administered oxygen at rate higher than ordered.
- Wrong dose of clindamycin on POC and in patient's med planner; SOC longer than 48 hrs. from referral and no physician order to delay the SOC; nurse suggested MiraLAX for constipation but no order and doctor not consulted; No order for PT eval that was done; nurse instructed client to use Imodium but no order for med; nurse used triamcinolone cream which had no order instead of the ordered Lotrimin; no orders for home health aide visits that were completed; RN directed use of OTC meds without a physician order
- Agency obtained an order from a NP for nurse to draw blood for lab testing but there was no order from a physician to provide an extra SNV to draw the blood; a client was transferred and admitted to a hospital and then returned home, the clinical record failed to include orders to resume SN services;
- Only as ordered by a physician: Patient #1 Patient purchased Tylenol and nurse instructed patient on use but there was no physician order in the chart. Also, RN encouraged this patient to check blood sugar, client was unwilling and asked RN to complete, surveyor noted that there was no order for RN to check blood sugar. Patient #2 assessment documents that client is to check blood sugar daily, patient is unable and unwilling to do this and the RN checks the blood sugar - the POC lacks an order for RN to check blood sugar.

- Failed to get wound measurements, lack pulse o2 readings, failed to document o2 use correctly; no order for o2

G584

- Verbal orders must be accepted only by authorized personnel according to state law and internal policy. Orders must be documented in the clinical records, sign, date and time the orders. Nurses did not document the verbal orders including signing, dating and timing by the nurse receiving the order.
- Missing documentation of verbal orders and follow up. Clinical record did not have evidence of verbal order to change of medication. Change was shown on medication list only.

G590

- Agency failed to report patient status changed (weight change and wound changes)
- Physician not notified of new open wound, no measurements taken by nurse of 2nd new wound.

G598

- Did not communicate to the physician plans for patient discharge from the agency. No discharge order or summary was sent to the physician.

G604

- Integrate all orders: did not coordinate care provided by all physicians and integrate orders. Plan of care not updated with verbal orders and primary physician not notified of orders obtained from consulting physicians. Services were delayed per patient request and no order obtained to delay services.

G616

- Med list in the home did not include revised order for warfarin and new order for Tizanidine;

G618

- Review of agency folder left in home revealed the plan for HH form lacked any entry in the section for Treatments to be done by HH team and only instructions on form was for HH to use the front door; no mention of nurse or OT;

G622

- Name and Contact of Clinical Manager: No documentation that the name and contact information for the Clinical Manager was provided to 4 out of 4 clients sampled.

G682

- Infection Prevention: staff did not provide cares in accordance with accepted infection control standards of practice in 3 out of 7 home visits. Staff member did not sanitize hands before reaching into bag to get equipment. Also did not sanitize equipment before placing it back in bag. Staff touched computer and patient without sanitizing hands. Nurse did not sanitize hands in between glove changes. Nurse failed to remove soiled gloves and failed to sanitize her hands after touching the patient and prior to entering her bag.
- Staff nurse failed to sanitize the computer and the small bag prior to placing inside the large bag
- Infection Prevention: During home visit RN touched the patient, reached into nursing bag to remove hand sanitizer, BP cuff, stethoscope without washing her hands. Medications were set up without prior hand washing. Laptops were not cleaned prior to being put back in bags.

G684

- Failed to sanitize equipment before placing into clean bag.
- Failed to re-sanitize tablet after use

G710

- Provide services in the POC: Patient #4 POC included an order for vital signs and pulse ox every visit: Visits lacked documentation of a pulse ox level. Patient #2 POC included orders for vital signs, pulse ox, and wound dressing changes 3 times per week: Vital signs and pulse ox were only completed on first visit of the week with the full visit to include wound measurements.

G718

- Communication with physician: Patient #4: had orders for Lactulose but family was using MOM and agency staff did not obtain clarification from physician or obtain orders. Patient #1: POC identified an allergy to Tylenol - SN note indicated that the client had purchased Tylenol and the nurse encouraged the client to use the Tylenol for pain as the client stated they did not have an allergy. RN did check with NP who reported no true allergy to Tylenol but there was no order in the POC. Patient #3 was receiving PT services, but clinical record lacked orders for services.
- Clinical record lacked documentation of follow up to physician regarding desire to change medication-lack of follow up. Physician not notified about patient refusal of certain cares (wound care)

G724

- Lack of documentation of any supervision performed by a RN and LPN.

G750

- CONDITION LEVEL: Home Health Aide Services. Failed to assure all aides were assigned specific, individualized task for each patient by an Agency RN (G798) Failed to assure all aides were providing services only as ordered by a physician and assigned by an RN (G800) Failed to supervise home health aides every 14 days when provided in conjuction with a skilled service (G808) Failed to provide direct supervision of the home health aide at least every 60 days when provided without skilled service (G814). Failed to include all of the required components when supevising home health aides. (G818)

G768

- Home Health Aide was to do percussion of chest and back but no evidence that aide was comped on this task;
- Competency evaluation. No documentation of competency evaluation prior to Adie applying pneumatic compression wraps to lower extremities and apply a surgical boot. One aide lacked documentation of competency evaluation for all basic skills.
- Failed to have aide competized (evidence of) on ointments and Ted hose
- Home Health Aides were not competency tested on extra skills. Skills not signed off by RN-for competency testing

G798

- HHA Assignment and duties: did not provide individualize and specific written patient care instructions from an RN in 3 out of 9 records sampled. Did not specify which type of bath to provide. HHA did not specify which type of bath was completed. HHA assisted patient with ambulation - PT had determined the patient always needed a gait belt with ambulation. This was not specified in the HHA assignment but HHA reported she always used a gait belt.
- Patient's clinical record lacked an aide care plan for tme period 11-14-19 thru 1-2-20. Aide care plan directed aides to perform "foot care" each visit - but failed to document what "foot care" meant the aide was to perform. Clinical aide care plan lacked aide care plan for time period 1-21-20 thru 3-20-20.

G800

- Services provided by the HHA: HHA failed to provide cares only as ordered by the physician and/or as directed by the skilled professional for 5 out of 9 sampled patients. HHA did not complete ROM and/or bath and gave no reason (N/A or omitted) for the omission. HHA did not assist with bathing, dressing, or applying lotion after bath - no reason. HHA signed and dated visit record but did not record any interventions completed. HHA did not apply

lymphedema wraps noting "not today" , "not needed" or no reason. HHA shampooed client's hair without orders. Did not transfer client. Provided additional unassigned task of "providing emotional support". HHA did not contact supervisor before performing unassigned tasks.

- Aide care plan said shower or sponge bath but aide documentation did not indicate which type of bath was completed;
- Documentation by the aide that she assisted the patient with showering, shampoo, dressing, ambulation, foot care and lotion without direction from the nurse as there was no aide care plan for this period of time. Aide care plan directed aides to perform a sponge bath, apply lotion, foot care, assist with dressing upper body, apply surgical boot: 1) Aides documented assist with ambulation with no direction from RN and did not document application of surgical boot; 2) aides documented giving client a shower without direction from RN. Aide care plan directed aides to clean/file nails: aide visit notes laced documentation indicating the aide cleaned nails. Aide care plan directed aides to assist with upper and lower dressing: aide documentation lacked documentation of this. Aide visit note documented application of antifungal powder to patient's skin without an assignment/direction by RN.
- Orders not followed by aide on aide care plan, (failed to document-showers, standard precautions,

G808

- Onsite supervisory visit every 14 days: not performed for 2 out of 4 patients sampled.
- Failure to complete every 14-day aide supervision.

G814

- Non-skilled direct observation every 60 days: missing in 1 out of 2 patients sampled. Documented supervisory visit but stated no HHA was present.

G818

- HHA Supervision Elements; In 5 out of 9 patients' supervision of the HHA did not include all of the required supervisory elements.

G940

- CONDITION LEVEL: Organization and Administration of Services. Agency did not comply with CMS requirements for branch offices.

G974

- Direct Support and Administrative Control: Agency is not providing direct support, supervision and administrative control of each branch office on a daily basis with patients only receiving services from the parent office. All

phones automatically roll over to parent office and do not ring into that office. One office is housed in a nursing home and nursing home staff are paid to be the "store front" for that branch. Agency advertising and promotional materials show no addresses or phone numbers for these offices. One office is not usually staffed and only used for a meeting area and charting. No patient charts were on site. One office listed as a branch had an address that was no longer valid.

G1012

- Clinical record includes current information associated with the current episode. Agency policy states clinician must complete all clinical progress notes on the day services were rendered. Patient #3 admitted on 12-9-19 with wound care three times a week - surveyor accompanied RN to Visit on 3-3-20 at which time the wound was healed: patient reports wound healed within 3 weeks of admission; Nurse notes continued to document a wound assessment approximately 2 months after wound healed. Patient
- Patient #5 had an OT visit on 2-27-2020 but was not competed until 3-1-2020 which exceeded agency policy by 3 days. There were several visits not completed in the timeframe set in policy by agency.
- Required items in clinical record: Patient #4 lacked an order for change in formula. Also, an order for patient #9 was found in chart of Patient #4. Patient #10 surveyor found an order for this patient in Patient #5 chart. Patient #11 - surveyor found an order for this patient in Patient #5 chart.
- No updated working plan of care; documentation not completed within 48 hours per agency policy

G1014

- Interventions and Patient Response: failed to include accurate and specific documentation of interventions and maintain them in the patient record in 2 out of 5 sampled patients with wounds. No documentation of wound measurements.
- No measurements of "eschar at the tip of the thumb"; another client had a venous ulcer and there were only measurements for length and width, lacking depth measurements; left buttock wound had only LxW measurements, no D;
- Interventions and patient response: Agency policy identified agency staff would inspect and evaluate the condition of wounds including size and location and measurements weekly. Patient #6: measurements included length only.
- Wound measurement not taken
- Interventions, wound measurements not documented, did not specify wound measured

G1022

- Discharge and Transfer Summaries: No transfer summary sent within 2 days of knowledge of the occurrence in 5 out of 5 sampled patients requiring a transfer summary.
- Transfer summaries sent to physician outside of required 2 days; transfer summary not sent to receiving hospital; transfer with discharge summary sent to the physician 29 days after the actual transfer
- Agency failed to send transfer summaries within 2 business days of patient's transfer and discharge summaries within 5 business days of patients discharge in 3 of 4 sampled charts.
- Discharge and transfer summaries not documented in patient clinical record

G1024

- Authentication: agency failed to ensure all documentation in clinical record included a date, time, staff signature and staff title for 3 of 3 sampled charts.

E 009

- Local, State and Tribal Collaboration Process: Emergency Plan failed to include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials to maintain an integrated response, including documentation of the agency's efforts to contact such officials and of its cooperative planning efforts

E 017   No Individualized Emergency Plans were developed as part of the comprehensive assessment in 4 out of 17 sampled patients.

- No documentation in Update to comprehensive assessment that nurse reviewed or completed an individualized emergency preparedness plan with the patient; patient's binder included a copy of an Emergency Preparedness form that included generic emergency info, not individualized; clinical record lacked an individualized emergency preparedness plan;
- Agency's policy for Disaster/Emergency Plan failed to address the need for agency staff to develop/review emergency preparedness plans with the patients with each comprehensive assessment;
- Emergency Preparedness-patients do not have individual emergency plan for comprehensive assessment and/or resumption. Forms in home folder for Emergency Plan in patient home were incomplete.

E-019

- Homebound HHA Inform EP Officials: Emergency Plan had no policy for the development of a procedure to inform State and local officials specifically of homebound patients in need of evacuation.
- Agencies policy did not include development of a procedure to inform state and local officials of homebound patients in need of evacuation due to an emergency.

- Did not have lack of policy and procedure for notification of agencies and officials of evaluation of homebound patients due to emergency situations.

E-021

- Procedure for follow up Staff/Patients: Emergency Plan had no procedures to inform State and local officials of any on duty staff and patients they are unable to contact in the event of an interruption of services related to an emergency.
- Agency failed to complete a written emergency preparedness plan that included procedures to inform state and local officials of any on duty staff and patient they are unable to contact.
- Agency failed to have a policy to notify state and local officials of any on duty staff or patients the agency was unable to contact.

E 023

- Agencies emergency preparedness plan did not include policies of a process to protect patient documentation and a process to keep the information from unauthorized access in the case of an emergency

E 024

- Agency failed to develop policies and procedures to address the use of volunteers or other emergency staffing during an emergency.
- Agencies emergency preparedness plan lacked a plan/procedure for use of volunteers in an emergency situation.
- No policy or plan procedure for use of volunteers for emergency or emergency planning

E 031

- Emergency Officials Contact Information: Emergency Plan did not include contact information for Federal emergency preparedness staff.

E 032

- Primary/Alternate Means for Communication: failed to provide documentation that the hospice maintained an emergency plan that included primary and alternate means of communication with the State and regional emergency management agencies.

E 036

- EP Training and Testing: the agency failed to ensure training in emergency preparedness to all existing staff and contracted staff.

E 037

Therapy staff did not received training in emergency preparedness for the HHA (the HH agency staff and therapy staff are all employees of the hospital and the therapy staff ony receive training in emergency preparedness for the hospital)

- Agency did not have documentation of emergency preparedness training for contracted staff.
- EP training: Agency failed to provide documentation of completion of EP training for 4 contracted staff.
- Did not train staff on Emergency Preparedness