Iowa Health Care Association
HHA Survey Review G-Tags
December 2015

The five most frequently cited tags from the 5 recertification surveys (0 deficiency free), 1 complaint (0 unsubstantiated), 2 revisits (both no deficiencies), recently reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 39 total deficiencies. **There were no condition level deficiencies and no partial extended or extended surveys.**

Total # of reports: 8
Total # of surveys deficiency free or unsubstantiated complaints: 0
Average # of deficiencies (all)

- **All = 4.9**
- **Recertification =7.8**
- **Complaints=1**
- **Revisits=0**

G-158 (42 CFR § 484.18) **Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine**.)
1. A review of the patient's clinicl record identified the patient received skilled nursing services on 5/4/2015, and home health services on 5/1 and 5/82015. The clinical record lacked evidence the agency obtained a verbal order from the patient's physician prior to the delivery of services, authorizing the agency to provide home health services to the patient from the end of the certification period on 4/28 until 5/10/2015.
2. Patient's care plan documented use of wheelchair, but no other DME or supplies used by the patient. Surveyor accomopanied RN to patient's home. surveyor observed an attached electric lift to the living room ceiling, over the patient's recliner and electric wheelchair, with separate cushion, a stair lift to the basement, and pill minders. Plans of care didn't identify any of these needs.
3. Failed to provide services per POC. Patient 1: physician's orders called for skilled nursing visits 1 time per week; POC called for use of jejunostomy feeding tube for feeding and calorie intake; patient lost considerable weight with no notification to doctor. Resident 2: POC ordered social worker to "assist family in accessing community services" The order failed to identify a visit frequency or duration. Resident 3: lack of documentation of registered dietician services.
4. Failied to provide for provision of services. Patient 1: POC included skilled visits 1-2 times per week for wound care; but lacked documentation of any other physical assessment. Patient 2: Lacked any documentation of other physical needs. Patient 3: lacked physician's agreed upon specific medical signs and symptoms that would require a PRN/as needed to visit as required by physician.
5. Failure to document fall and visit to emergency room. Failure to adequately asses and treat pressure ulcer.

G-159 (42 CFR § 484.18(a)) **The plan of care developed in consultation with 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.)

1. HHA failed to ensure accurate completion of all components comprising the plans of care for 10 of 12 sampled patients. Patient 1: Patient's care plan documented use of wheelchair, but no other DME or supplies used by the patient. Surveyor accomopanied RN to patient's home. surveyor observed an attached electric lift to the living room ceiling, over the patient's recliner and electric wheelchair, with separate cushion, a stair lift to the basement, and pill minders. Plans of care didn't identify any of these needs. Patient 2: Patient used cane, walker, wheelchair; POC listed no other DME use. Surveyor observed on home visits attached rail to hospital bed, soaker pads, disposable chux pads, etc., that were not documented in POC. The remaining 8 HHA patient visits observed by the surveyor had similar issues: failure to document DME needs/use in the patient's POC.
2. Agency failed to ensure accurate completion of all components comprising POC for 5 residents: patient 1 POC to give ibuprofen every 8 hours, POC did not include documentation of physician approval. Patient 2 Nystatin ointment 100,000 units per gram apply to affected area prn as directed by mother; POC didn't document dose, frequency or where to be applied. Resident 3: POC included suppository but didn't include type of medication to use in suppository. Patient 4's POC called for administration of "over the counter fiber supplement per package directions" but didn't specify which fiber supplement.
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G 332 484.55(a)(1) **The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.**

1. Patient referral to HHA dated 11/20/2014; initaial assessment 11/24/2014. Patient 2: start date of 7/1/2015, POC identified agency staff received verbal start of care from the physician of 6/8/2015.
2. Patient had start of care date of 2/28/2015 but clinical record included a hand-written referral intake form dated 2/24/2015.
3.

G 121 484.12(c) **Compliance with accepted professional standards and principles. The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.**

1. Failed to ensure staff complied with pharmacy regulations to ensure staff did not change the pharmacy label on a patient's prescription bottle and put the patient at risk to receive an incorrect medication dosage. Staff set up patient's medications in a planner box for the next week.Staff reported she changed the pharmacy label on the box hand written in ink "Furosemide one tablet twice daily"; orgininal pharmacy order was once daily.
2. Staff bfailed to wash hands or sanitize upon entrance to home and providing services.

G 165 484.18(c) **Drugs and treatments are administered by agency staff only as ordered by the physician with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per agency policy developed in consultation with a physician, and after an assessment of considerations.**

1. Failed to follow physician's orders for treatments for 6 of 12 residents.

G 176 484.30(a) **Duties of the Registered Nurse Prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.**

1.RN failed to supervise and coordinate care for 2 of 16 patients. Patient 1: POC lacked any wound care orders for wound treatment. Patient 2: failure to document significant weight loss.
2. Parameter guidelines directed staff to notify the patient's physician if assessment data findings fell outside of agency-specific parameter guidelines. These actions were outside of their scope of responsibilities.

G 224 484.36(c)(1) **Assignment and duties of home health aide. Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide.**

1. Three of 9 patients surveyed: patient 1's task sheet directed HH aide to provide skin care with no clarification. The nurse's notes failed to define what "skin care" meant. Patient 2: again, task sheet listed "skin care" with no explanation of what needed to be done by the HH aide. Patient 3: POC included directions that the aide provide/assist the patient with a shower or sponge bath. The assigmentment lacked specific direction explaining with one, shower or spongae bath, the aide should administer, and under what circumstances the aide should provide either one.
2. Five instances out of 6 patients surveyed of failure of agency to provide home health aides of with patient specific and individualized written instructions completed by an RN placed patients at risk to receive inappropriate or inconsistent care by the HHA aides.