Iowa Center for Home Care
HHA Survey Review G-Tags
4th quarter 2016

The five most frequently cited tags from the 19 recertification surveys (1 deficiency free), 2 extended (0 deficiency free), 4 complaints (0 deficiency free), 4 revisits (4 deficiency free) recently reviewed by the ICHC Survey Results Committee are listed below with narrative. There were 189 total deficiencies. There were no condition level deficiencies and no partial extended. There were 5 Inability to Competize insufficiencies.

Total # of reports: 26
Total # of surveys deficiency free or complaints unsubstantiated: 1
Average # of deficiencies

- **All = 7.27**
- **Recertification =10.29**
- **Inability to competize=13.33**
- **Complaints=9.86**
- **Extended=13.00**
- **Revisits=1.44**

G-159 Acceptance of patients, plan of care & medical supervision, plan of care covers all pertinent diagnosis

- Agency failed to ensure accurate completion of Plan of care; PRN lacked frequency and reason for medication.
- Plan of care failed to include duplicate orders for Nystop, Maalox, santyl, but did not instruct which were to be applied/administered.
- Agency failed to complete accurate completion of plan of care; plan of care did not list pressure chair measures.
- Agency failed to complete accurate completion of all components of patient's care plan.
- Patient's plan of care failed to identify numerous other durable medical equipment in the patient's home.
- Agency lacked documentation on durable medical equipment supplier; e.g., lifeline, CPAP diabetic supplies, etc.
- Agency failed to ensure accurate complete of the plan of car by clinical staff, and the plan was current with durable medical equipment documentation; failed to include goal-specific discharge plan; and under what circumstances discharge would occur; e.g. Medicaid or long-standing client; did not include safety measures in patient's plan of care.
- Agency failed to get physician's order for specific aide tasks or documentations in clinical record of same.
- Non-specificity to location of cream, reason why PRN was ordered.
- Plan of care: no documented reason for PRN acetaminophen; no documented reason for PRN Tramadol; no entry in prognosis section of the plan of care; many other PRN meds lacked documented reason; plan of care listed metabolic diet but also referenced a general diet; functional section left blank; No physician order on plan of care for oxygen although all notes referenced oxygen; no rehab potential on OPOL, no reason for maximum dose of lidocaine.
- Plan of care: durable medical equipment not listed on plan of care (bath bench, grab bars, call light, diabetic supplies electronic scooter, WW, ERS; PRN medications administered with no documented reasons.

- Plan of care: PRN medications listed but no instructions regarding symptoms or when to use; no administration frequency, amounts not identified, incomplete. Discharge plan was not specific; did not include rehabilitation potential for patient.

G-170 Plan of Care—duties of the registered nurse

- Agency failed to ensure RN provided care as ordered; clinical record lacked physician's order for increased dose of medication; clinical documentation lacked measurement of patient's weight and wound care initiatives.
- Patient's clinical record lacked documentation identifying that nurse contacted physician's office to obtain order to perform two additional visits
- Skilled nursing services: orders for skilled nursing services three times per week to assess wounds; documentation on numerous visits did not include measurement of wound size, stage, drainage, etc.; orders for pulse oximetry and weight measurement on patient lacking for patient with congestive heart failure; notes failed to consistently show skilled nurse obtained pulse oximetry and weight measurements; multiple instances of clinical staff not reporting weight gain outside of parameters to physician; no documentation of blood glucose except one visit when it measured 323; no order for milpelex.
- Agency failed to ensure agency provided care as ordered; order was for head-to-toe assessment, including vital signs and patient's weight measured during each home health aide visit; multiple instances of patient's vital sign measurements not being recorded; orders to set up patient's medications, but patient refused to take with not documentation why.
- Facility failed to provide skilled nursing care as ordered by the patient's physician; medication errors, wound care documentations not on care plan; failed to document as ordered pulse oxygen, etc.
- Skilled nursing services: skilled nurse visits conducted more frequently than call for in plan of care; diagnosis of congestive heart failure included patient weight measurement on each skilled nursing visit, but no weight documentation was completed.
- Skilled nursing services: clinical staff did not follow physician's orders—surveyor observed licensed practical nurse did not follow dressing change orders; did not report (per physician's orders) values outside of parameters for BS diabetic patient; no report to physician of multiple blood pressure readings outside of parameters; incorrect medications set-up nurse did not properly explain physician order to patient making the patient make "uninformed decision" not to take PRN acetaminophen; weight checks ordered but not completed with no documentation of why; out of compliance visit frequency for skilled nursing services; CPT vest not documented per physician's order; skilled nurse did not perform range of motion exercises as ordered, no documentation of ROM or PROM.
- Physician-ordered suprapubic catheter to be cleaned twice-daily, was only cleaned once daily.

G-176 Regularly re-evaluates patients' nursing needs

- Duties of the registered nurse: registered nurse listed a bath or shower in patient's plan of care; aide didn't say which; clinical orders for patient's weight to be taken on each visit; patient refused, physician was not notified of this; medications not on patient's plan of care were available (Advil, fluticasone, saline spray); clinical staff did not notify physician of medical non-compliance, did not notify physician of patient's orthostatic blood pressure reading outside of parameters.
- Registered nurse failed to report changes to physician changes in the patient's vital signs that were outside of parameters; did not report five-pound weight gain in one week.
- Lack of evidence nurse requested referral for occupational and physical therapies or informed physician of patient's perceived need for physical therapy services, failed to identify appropriate services for patient's needs; late medical social worker assessment, eight days per agency policy

nurse care manager failed to coordinate care in a timely manner; ROC—order to resume physical and occupational therapies failed to provide physical therapy after a hospital stay; patient reported during home visit home health aides were doing extra tasks not assigned, including shaving, applying Nystatin powder to an area other than assigned and then applying lotion; therapy evaluations ordered but not performed, no coordination of care; untimely coordination of care; aides assessments not followed; orders not followed.

- Agency failed to ensure registered nurse coordinated patient care with the physician; registered nurse did not follow agency parameters for measuring vital signs and report to physician.
- Agency failed to ensure nurses coordinated care with the patient's physician; physical and occupational therapy received May 12 but not started until six days later; with no documentation of why; lacking notes to physician regarding wounds on patient's legs.
- Plan of care failed to document any changes related to the patient's new diagnosis; medications document read "no changes" home health aide care plan did not follow this; agency failed to communicate any changes to the care plan.
- Agency clinical staff failed to communicate patient's changes in condition to patient's physician.
- Agency failed to communicate; wrong medication administered, agency failed to notify patient's physician regarding change of condition.
- Agency policy—physician to be notified of any change on the patient's vital signs or other clinical findings (BP, BS, weights, etc.); aide assignments not updated by nurse; aides doing more than assigned.

G-224 Written instructions by the RN or therapist

- Agency failed to provide individual and specific written care plan instructions
- Agency failed to provide individualized patient care plan; agency failed to complete specific patient care instructions from the agency to the home health aide.
- Agency failed to ensure implementation of specific written specific instructions to be followed by home health aide for care plan for patient.
- Agency failed to clarify specificity in the home health aide care plan.
- No specificity; care plan not specifically tailored to patient's needs.
- Registered nurse did not specifically document in care plan for instructions on tasks; clinical staff failed to identify which type of care to be given when multiple choices presented.
- Assignment and duties of the home health aide: directions by registered nurse for tub/shower, partial or complete bed bath; instructions lacking for under which circumstances to provide each one; skin care ordered without identifying what specific type of skin care.
- Registered nurse failed to provide individualized and specific patient care plan to home health aides.

G-236 Maintain clinical records in accordance with professional standards

- Clinical records: home health aide visit notes not locked within agency timeline protocol and many notes not electronically signed as completed; some notes not signed and dated electronically; some just not signed electronically.
- Agency failed to maintain up-to-date patient clinical records, including legible, clear and accurate documentation.
- Agency failed to maintain patient clinical records with pertinent, accurate, consistent and timely information; patient discharge summaries had not been signed by physician.
- Accurate complete and timely records: Medications found in home not on medications list; skilled nursing visits note electronically signed within agency timeline protocol; ARNP signed order, agency nurse wrote in physician's name on order there was no documentation the physician approved it.

- Agency failed to maintain clinical records in a legible manner, failed to document up-to-date and timely; paper note documentation was not accurately dated and staff failed to follow documentation correction policies.
- Agency failed to maintain accurate, complete and timely clinical records; registered nurse visit notes locked within seven days per agency policy; home health aides did not follow the patient's care plan; there was no documentation as to why home health aides had missed patients visits.
- Agency failed to maintain patient records with pertinent, accurate, consistent and timely information; care plan called for wound vac on May 13; but still not on care plan June 18th through August 16th; clinical record did not have same address throughout the record; no orders on chart for physical therapy; registered nurse already had two documents already signed by the patient dating the additions.
- Agency failed to maintain complete patient medical records, completion of documentation within a timely manner; records lacked correct process for error and documentation; accurate documentation by aide inconsistent with plan of care; obliteration of documentation in conflict with agency policy.
- Completion of clinical record by other than skilled nurse performing visit.
- Clinical staff failed write over for error correction.
- Clinical records: agency did not follow own policy of visit notes complete within two calendar days of visit; documentation corrections—did not follow own policy when correcting; clerical error on medications record-wrong information on patient's chart (some other patient of agency); aide failed to document additional tasks provided but not assigned; visit notes outside of agency policy timeframes; duplicate drug therapies but failed to specify duplicate medications.
- Late signatures; late medications list.
- Clinical staff failed to follow policy in changes to clinical record by drawing through an error and writing "error," was not completed within agency protocol timeline of 36 hours.

G-337 Comprehensive assessment must include review of all meds the patient is currently taking

- Agency clinical staff failed to review medications at a time of each drug regimen review; 485 did not match drugs found in the patient's home.
- Medication reconciliation did not match what physician had documented.
- Inaccurate drug regimen review, outdated medications, or inability to complete for medications administered in the home.
- No DRR documented on SOC and ROC; medications list in client's file did not match how client took several medications and some medications patient took were not on medications profile; DRR did not include information about side effects and duplicate drug therapy.
- DRR: three of five sampled did not have complete and accurate DRR; plan of care had orders for Refresh eye drops patient was not using them; patient using Advil, Flutrsone, saline nasal spray, aspercreme, blue gel; other medications found in patient's bathroom patient said they were using, but not included on plan of care nor DRR.
- Drug regimen review: Duplicate medications unidentified; medications were not removed from the summary of current medications and the next plan of care—even though the patient was no longer taking the medications "too expensive" or "old" medications had not taken for "two years";
- Duplicate medications failed to be identified; drug medications regimen review failed to reflect accurately what medications the patient was using at the time of the visit; drug interactions not identified.
- Drug regimen review: no evidence of review of ineffective drug therapy; side effects; medications bottle label and order did not match; side effects not identifies; late recertifications incomplete on day due.