Iowa Center for Home Care
HHA Survey Review G-Tags
4th Quarter 2019

Total # of reports: 6
Recertification surveys: 4 (0 deficiency free)
Complaint: 0
Extended: 2 (0 deficiency free)
Revisits: 0
Inability to competize = 0
Validation survey = 0

Old CMS description of G-tags

New G tags

G372

- Failure to transmit OASIS data within 30 days.

G432

- Complaints not logged in the logbook.

G510

- Multiple failures with patient receipt at initial and start of comprehensive assessment; See G520, G536, G546, G548.

G520

- Failure to complete the comprehensive assessment within five calendar days of a patient's start of care.

G528

- Failed to include an individualized assessment relating to patient's current health status for clients. Nurse performing recertification assessment, rather than weigh patient at that time, asked the patient for current weight and used that in assessment.

- OASIS assessment was not comprehensive; GG0170 j, l, m, n marked not assessed with no reason as to why these were not assessed.

G536

- Fail to ensure agency staff completed drug regimen review included all required components (ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, noncompliance with drug therapy) of a drug regimen review with completion of each comprehensive assessment for several patients; noncompliance x 1 chart, duplication x2 charts, potential interaction x1 chart
- Failure to complete drug regimen assessment review at start/with update for multiple patients.
- Failed to perform a DRR in multiple records. During recertification visit nurse failed to review all patient meds. The surveyor found additional medications not reviewed and an expired medication. Nurse did not identify any duplicative therapies, surveyor identified multiple incidences of duplicative therapies. One client was missing duplicative therapies, significant drug interactions and ineffective drug therapy evaluations.
- DRR completed, but nurse failed to identify any duplicate medications on the DRR when patient did in fact have duplicate medications for difficulty breathing, pain, and vitamin supplementation.

G546

- Failure to ensure assessments in timely manner.

G548

- Agency failed to perform a comprehensive assessment within 48 hours of a patient's return home from a hospital admission. (Late on several clients - visits for assessments made but not completed within time frame specified by regulations.)

G574

- Agency failed to ensure the accurate completion of all components comprising the POC. POC listed catheter supplies, but foley was removed at physician office. Patient clinical record lacked evidence the physician was contacted and gave an order to discontinue some of the patient’s medications. Resumption of care order lacked order for mupirocin ointment.
- Components of the Plan of Care: Failed to include all components multiple patients. One POC did not list a transfer board or a drop arm bedside commode; Medications not updated after a resumption of care. Patient had a lifeline but not noted on the POC; One failed to list tubigrip and bedrail (PT orders); One POC listed 9 outdated medications; Client had order for 1 medication 1-2 PRN did not specify when to take two as opposed to one. Client had order for daily weights. Nurse asked patient for his weight and recorded it, patient later told surveyor he hadn't checked his weight "for a very long time". Scale was not listed under medical equipment for this patient. Pill splitter was not listed on POC; POC did not list an emergency call

system; POC listed several outdated medication orders. POC missing shower chair. POC listed a walker, grab bars, shower chair and wound supplies - no shower chair found in the home and patient said she had not had one for a year and a half.

G576

- Failed to update POC with new physician orders for multiple patients. Interim orders not included in POC.
- Agency failed to update POC with all new physician orders. Patient had orders to notify physician of heart rate less than 60, then agency received order to change to 50 and POC was not updated to the new order. Client POC had orders for indwelling foley which was removed at dr's office.
- All orders recorded in the POC; Did not update for several patients. Interim orders for PT, OT and ST services obtained following initial evaluation were not updated on the POC; Order for PT evaluation not added to POC; Interim order for lab draws not added to the POC; Interim order to discontinue medication and perform a lab draw not added to the POC. Interim order for a new medication and lab draw not added to the POC (several of these); Medication discontinued and POC not updated. More interim orders for therapy services not added to POC. Order to cancel SN and HHA for one week not added to the POC.

G580

- Failure to ensure staff obtain physician's orders for administration of medications, treatment and services provided by agency staff- put patients at risk.
- Failed to provide medications, treatments or services only as ordered by physician. Clinical record showed nurse lacked an order for dressing before applying it. Clinical record lacked a physician order to discontinue catheter.
- Only as ordered by physician - failed to administer treatments/services as ordered in multiple cases; Nurse set up med planner incorrectly with the wrong dosage in both patients. Stated was following patient's handwritten medication list and did not notify doctor and/or obtain corrected orders. Nurse checked INR without an order. Patient using higher dose of oxygen than ordered.
- Agency failed to administer treatments and services only as ordered by a physician. Order to increase health aide frequency signed by doc but no documentation that visits were increased and no documentation that doctor was notified of missed visits. Order for aide visits twice a day, but only one visit made with no missed visit sent to physician. Orders for every other week SN - one visit was made a week late with no documentation as to why this occurred.

G590

- Failure to communicate patient's status (a change in condition) with the physician.

G750

- Multiple failures with patient receipt at initial and start of comprehensive assessment; See G768, G798, G800, G808, G818

G768

- Failed to ensure home health aides successfully completed competencies in all basic home health aide skills which require a registered nurse or other appropriate skilled professional in consultation with a registered nurse to evaluation the competency of the aide by direct observation with a home health aide patient for home health aides hired since the last recertification survey and completed basic skills and competency evaluation after 1/13/18. * Home health aide competency evaluation form documented that the home health aide completed a competency evaluation in performing the skill of shampooing in either the sink or tube but failed to specify which one the home health aide completed and which shampoo types the home health aide failed to complete.
- Failed to ensure HHA was competently trained. Staff lacked competency in any assigned skill which exceeds the level of basic HHA skills.
- Failure to provide individualized written patient instructions from an RN for a HHA for multiple patients.

G798

- Failure of RNs to provide specific written instructions directing the care.

G800

- Agency failed to ensure home health aides provided care to agency patients only as ordered by the physician and/or as directed by the skilled professional assigning the home health aide to the patient for patients. **Order read shampoo hair every week - aid completed shampoo with each visit (twice weekly). Notes lacked documentation the aide contacted the nurse for approval to complete the additional task on the second visit of the week.
- Fail to ensure HH services are provided only as ordered by physician and according to care plan.

G808

- Fail to ensure RN completed HH supervision at least every 14 days for multiple patients.

G818

- Failed to ensure registered nurses supervision home health aides maintained documentation of a review of all required supervisory elements including following the patients POC maintaining open communication with patient/caregiver, demonstrating competency of all assigned tasks, complying with infection prevention and control policies, reporting changes in patient condition and honoring patient rights. Clinical note lacked documentation that the nurse assessed aide's ability to meet required supervisory assigned task (complying with infection prevention/control policies and procedures); Documentation had spots for competency with assigned task and complies with infection prevention and control policies but marked as "N/A" x 3 charts.

- Failure to document all required components of HHA supervision every 14 days when skilled services were provided in conjunction with aide services and every 60 days when no skilled services were provided.

G1012

- Required items in the clinical record - record did not have current orders and failed to ensure documentation was completed in a timely manner in multiple patients. Nurse did not document verbal order and drew labs without the verbal order she received. Visit notes completed later than 24 hours as specified in agency policy (several examples).

G1022

- Failed to send physician a summary of patient's care while receiving services from the HH agency in a timely manner.
- Discharge/Transfer Summaries (transfer summary not sent timely for multiple clients). Transfer summaries being sent 1 - 7 days late.

G1024

- Failure to maintain an appropriate clinical record/documentation.

E009

- Agency failed to have a written policy and procedure for cooperation and collaboration with regional emergency preparedness officials. Policy failed to include the process for cooperation and collaboration with regional emergency preparedness officials.
- Failure to have a process for collaboration with tribal, State and Federal emergency preparedness officials.

E017

- Failure to ensure clinical record had a copy of an individualized plan. Surveyor was unable to find a written emergency plan in the patient's home.
- Comprehensive Assessment in Disaster: Failed to complete an individualized emergency plan with the comprehensive assessment in multiple clients.

E019

- Agency failed to ensure agency staff developed a policy and procedures to inform state and local emergency officials about homebound patients in need of evacuation due to emergency situations. Agency assigned priority codes to patients but not how they would inform state/local emergency preparedness officials of need for evacuation of patients.
- Failure to have a process for informing state and local officials of homebound patients in need of evacuation.
- Inform EP Officials of Homebound Patients - missing a procedure to inform officials of homebound patients.

E021

- Agency failed to ensure the development of a written policy and procedure 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.
- Failure to have a process for informing state and local officials of any on duty staff and patients they're unable to contact in the event of interruption of services related to an emergency.
- Procedures for follow up Staff/Pts: No policy and procedure for informing officials of any patients or staff you are unable to contact in an emergency.

E023

- Policies and Procedures for Medical Documentation: Policy did not preserve medical documentation, protects confidentiality and maintains availability of patient records during an emergency.

E024

- Agency failed to have a written policy and procedure for the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of state and federally designated health care professionals to address surge needs during an emergency.
- Failure to address use of volunteers and other emergency staff strategies during an emergency.

E037

- Agency failed to ensure training in emergency preparedness for all employed staff and all individuals providing services under arrangement (contract staff), consistent with their expected roles over multiple years.
- Failure to ensure emergency preparedness training documentation for all existing staff.

E031

- Failure to include contact information for state, federal and tribal contacts in the emergency preparedness communication plan.

E039

- Agency failed to ensure participation in two emergency preparedness exercises in.
- Failed to ensure participation in two emergency preparedness exercises in a year.