Compliance Tips from IHCA's Home Health Survey Results Committee

June 2015

Breakdown of Survey Type:
15 Recertifications
1 Partial Extended
0 Extended
6 Complaints
5 Re-visit

Number of Deficiencies:
111

Number of Agencies with Condition Level Deficiencies Resulting in an Inability for Agency and its RNs Prohibited from Providing Competency Training of Aide: 1

Top 5 Most Frequently Cited Tags (listed below)

1. G Tag 236

- Agency failed to melanin an accurate clinical record. Misfiled documentation, obliterated corrections, no dosage on medications, inconsistent date in electronic records and lacking documentation of HHA visits.

- Agency failed to follow own policy on correction errors in charting. Also, failed to have timely and accurate charting (incorrect medication list).

- Therapy notes were not incorporated into clinical record within 7 days as agency policy required. No clear documentations for medication regimen review. Electronic signatures did not match actual time of visit within the note. Clinical record entries lacked dates or signatures. Improper entries not corrected properly.

- HHA did not identify in documentation where bath or shower was given.

- Correction of errors did not follow agency policy. Vitals ad treatment flow sheets lacked respiration.

- Failed to follow policy to have records electronically signed within 2 business days and there were not. X2

- Failed to have documentation charted within 2 business days.

- Error correction had not been initiated by the physician.

- Failed to maintain accurate clinical records because record lacked documentation of when HHA visit occurred.
- Clinical records failed to contain adequate documentation about a patient's changing condition – client subsequently died.

2. G Tag 224

- Agency care plan lacked directions for specificity of duties and not individualized x2
- HAH assignment sheet not specific about care to be provided, when to provide either shower or bath. Assignment sheet does not provide instructions when HHA should call RN
- Agency skills checklist used to trained HHAs did not provide description regarding foot care techniques, yet this was routinely assigned to HHAs
- No specific direction to HHA regarding when to give shower or sponge bath. Lack of specificity of where to apply lotion. No direction on HHA assignment sheet regarding the application of leg braces.
- Agency failed to provide individualized instructions to HHAs. X2
- Facility failed to provide instructions on skin care (where to provide skin care) and not specific on when HHA to call RN.
- Care plan indicated directions to provide skin care and foot care, but lacked specific directions on what to use and how.
- Did not specifiy what "personal care meant.

3. G Tag 172

- Failed to follow agency policy for wound care. Failed to measure wounds due to deterioration and no documentation of measurements.
- Failure to reassess and re-evaluate patient's needs, vital signs, wound care and measurements.
- Nurse failed to measure length and width and depth of wound as least weekly and document in clinical records. Nurse also failed to record patient's weight after starting patient on new diuretic for 3 + pitting edema and weight gain at previous visit
- No wound measurements documented. X3

- Wound not assessed with length, width and depth. Failed to also check orthostatic blood pressure after patient complained of being dizzy.

- Lacked documentation of a temperature reading while on antibiotics. Elevated temp. may be an indication that antibiotic is ineffective.

4. G Tag 159

- DME- inaccurate listing- lifeline lift chair not on list. Inaccurate medication list.

- Plan of care did not contain a reason for tramadol, Tylenol; did not document functional limits, activities permitted, mental status and no frequency or reason for as needed medication noted.

- Nurse did not identify med dispenser as durable medial equipment in locator box 14. Plan of care also failed to identify commodes, wheelchairs and leg braces. Plan of care identified diet to be regular but the physician orders on other parts of the record called for diet to be strict low carbohydrates and no contact was made to physician to seek clarification.

- Physician orders lacked frequency of as needed medications. Physician order for Combivent inhaler did not specify medication dosage per actuation of inhaler. Orders for Nystatin powered as needed not specify location for use.

- Medication orders did not include reason for as needed unsigned doctor orders. X2

- MD orders lacked identification of the reason why the patient was to take medications. Plan of care also lacked a principal diagnosis.

- Plan of care did not identify commode as DME. Did not identify portable blood pressure as DME. Did not list gait belt as DME.

- Lacked documentation of C PAP as a DME. Lacked documentation of a wheelchair, shower chair, grab bar and a raised toilet as DME. Lacked a mechanical lift as DME.

5. G Tag 158

- Failed to provide services according to physician orders. Vital signs and medications order contained signature other than a physician. Lacked timely order for therapy.

- No interim order to continue services until plan of care signed and returned and failure to follow wound care orders.

- Frequency of HHA visits provided did not match the physician order and physician was not notified of changes; nurse failed to check blood sugar as ordered by physician and no notification of missed therapy visit when patient was not home.

- Physician orders called for nurse assessment of patient medication compliance and no documentation of this occurring in clinical record.

- Agency failed to contact physician for new orders before starting treatments.

- HHA failed to obtain an MD order for an extra nursing visit in a timely manner.

Tags Resulting in Condition Level Deficiencies on Recertification Surveys