Iowa Center for Home Care
HHA Survey Review G-Tags
June 2016 (2nd quarter 2016)

The five most frequently cited tags from the 13 recertification surveys (0 deficiency free), 1 extended (0 deficiency free), 1 revisit (0 deficiency free) recently reviewed by the ICHC Survey Results Committee are listed below with narrative. There were 137 total deficiencies. **There were no condition level deficiencies and no partial extended. There were 4 Inability to Competize insufficiencies.**

Total # of reports: 16
Total # of surveys deficiency free or complaints unsubstantiated: 0
Average # of deficiencies (all)

- **All = 8.6**
- **Recertification =10.5**
- **Inability to competize=13**
- **Complaints=0**
- **Revisits=3**

G-236 Maintain clinical records in accordance with professional standards

- Agency clinical personnel failed to complete entries into clinical records with seven days.
- Agency failed to maintain clinical record to completely contain accurate information, and ensure staff completed in timely manner , electronic signature reverted back to visit date versus completion of visist date, visits not logged in timely manner, clinical record lacked a discharge comprehensive assessment.
- HHA assignment said "apply compression or TED hose," HHA didn't indicate which type of stocking was applied, no date or nurses signature on POC, documentation to continue services was two weeks after POC end date, nursing note not electronically signed until one week after entry.
- Handwritten corrections to printed POC not dated nor initialed and thus cannot be verified to date of entry, other corrected entries lacked "Me" label, date and initials and initials of staff as policy mandates.
- Plan of care start of call date did not match voice message from physician.
- Clinical records lacked therapy visit documentation, pencil documentation on record, part was erased which was not proper correction according to agency policy, HHA did not specify which care provided when less than one option was given., therapy records not submitted to agency timely, incorrect date on referral form, whiteout on notes, parameters cited on POC as no documentation to show physician contacted to set appropriate parameters.
- CNA's notes not incorporated into agency records according to agency policy (not timely).
- Clinical records—agency failed to maintain accurate and authenticated data for 5 of 19 residents, many not signed electronically by nurse, lacked orders for OT, and aide services.
- Clinical records—nine of ten reviewed lacking timely documentation, missing dates and signatures notes not incorporated into clinical record within 30 days (per agency policy), current medication list missing, untimely supervision of aides.
- HHA documentation did not specify which bath given, shower or tub bath, typographical error on recorded temperature, orders not clear for staple Remeral.
- Documentation errors not corrected according to agency policy, all documentation not incorporated into clinical record, clinical record contained conflicting start of care date, drug

regimen review did not identify all medications nor identify D\C'd medications, no documentation I record whether lab draw was completed in home or at hospital.

- Agency policy directed clinicians to maintain a current, accurate list of patient medications with the clinical record, entries to be dated and authenticated by entry's author, the agency's therapy tracker was on leave and entries were not being entered within 24 hours per agency policy, often 3-4 days later.
- Agency documentation policy directed staff to correct handwritten errors with a single line through the error, date and initial, all documentation to be completed with 24 hours, aide documented tub/shower without specify which, VOID written over entry, obliterating it.

G-176 Regularly re-evaluates patients' nursing needs

- Physical therapy record not entered into HER until six days after physician signed order; clinical record lacked evidence of communication between therapy and HHA regarding order.
- Nurse didn't verify medication changes reported by client reported by patient from an ER visit with an ER physician.
- Duties of RN—didn't promptly alert physician to new wound, didn't alert physician to patient's inability to monitor own pulse, medication setup with PRN didn't inform physician patient taking medications daily.
- RN lacked timely initiation HHA services for recommendation of OT evaluation, three-day delay in faxing lab results to physician, clinical indication patient was worsening but RN didn't report to doctor over delayed period of time, patient using spouse's 02 but nurse didn't notify doctor.
- Agency RN failed to report changes in patient condition to physician—did not notify physician of new wound, clinical record lacked SV notes for nursing visits, did not draw labs as ordered.
- Agency RNs failed to report changes in patients' conditions and/or vital signs and other clinical findings outside of identified POC parameters to the physician for three residents.
- Agency failed to ensure RNs supervised and coordinated patient care with physicians and providing services, case communication note said patient's family "struggling" to provide care and asked for physician to approve visit by medical social worker. RN failed to follow up on the request.

G-172 Prepares clinical & progress notes, coordinates services, informs physician of changes

- Incomplete weekly wound measurements as ordered by physician and mandated by agency policy (no depth measured); "superficial" wounds not measured for depth.
- POC missing location, frequency and reason for medications; failed to list depends failed to identify parameters.
- Duties of RN: missing wound measurements for three patients, depth, length, did not check blood pressure with possible changes on patient complaint of dizziness on home visit.
- Documentation lacked wound depth for superficial wound.
- Agency nurse failed to adequately assess patient's status and response to care, staff did not measure wounds.
- Agency failed to ensure nurses adequately reevaluated patient's status and respond to care, a list of agency policies included a policy directing staff to in wound assessment criteria and protocol, of the policies provided none included specifications as to what entailed a wound assessment or agency-specific expectations when patients developed or had open wounds.
- Regular re-evaluation of patient's nursing needs for four patients, including RNs not following agency policy for continual wound assessments, including measurements in cm, length, width and depth.

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

- Agency failed to maintain complete and accurate care plans, nurse documented 5 mg on Tuesday/Thursday with 4.5 mg every other day. Physician's orders called for 5 mg Monday, Wednesday, Friday, Saturday, Sunday and 4.5 mg Tuesday and Thursday.
- No date on verbal order SOC, didn't address "rehab potential" section on plan of care, all DME used in home not listed in plan of care, (bath bench, hand held shower.
- RN did not verify medication changes reported by client from an ER visit with ER physician n, prn medication not specified, glucometer not listed as DME.
- Improper use of mechanical lift and medications.
- Medications not administered properly, cough drops not on POC; side rails, air mattress, mechanical lift chair, tube socks not in POC.
- POC had no discharge plan, incomplete medications orders (PRN why use, daily 02 use daily needed need to be more specific regarding when used, PRN didn't include specific use frequency.
- POPC didn't specify who was to give IV, HHA or doctor's office, orders for therapy visits continued on recertification but therapy had already been discharged, no discharge plan identified in POC, unclear NSS order for frequency and duration, rehab potential not on 485, activities potential not identified.
- All DME used in home not identified on POC.
- Agency failed to ensure accurate completion of all components of the POC, agency using ICD 9 codes instead of ICD 10, PRN medications lacked frequency and maximum dosage, not all DME products listed on POC (grab bar, nebulizer, incontinence briefs, glucometer).
- Agency failed to ensure accurate completion of all POC components and that the POC contained current information.
- POC failed to contain current information for nine residents, particularly would care instructions, POC failed to list DME (lift, stairglide) installed six years ago.

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

- No changes on medications order or drug regimen review after physician changed medications at office visit, Colace was not listed on POC even though patient and nurse discussed during HV.
- Drug regimen review failed to contain expired medications found, not correct on medication profile.
- Drug regimen reviews not completed for all drugs.
- Agency failed to ensure DRR included all current medications used by patients, agency did not identify duplication in pain medications, and patient's POC missing documentation of missing medications that patient was taking.
- Agency policy mandated RN to review medications list to maintain accuracy, including OTC medication and monitor for potential side effects, RN failed to identify expired hydrocodone at time of recertification comprehensive drug regimen reviews.
- POC called for 1000 mg fish oil twice per day; family member who set up reported was supposed to be 650 mg twice per daily.