Iowa Center for Home Care
HHA Survey Review G-Tags
1st & 2nd quarters 2017

Survey type: 25 recertification surveys (0 deficiency free), 1 extended (0 deficiency free), 5 complaints (0 deficiency free), 5 revisits (2 deficiency free) 5 inability to competize (0 deficiency free) and 1 validation survey (0 deficiency free) recently reviewed by the ICHC Survey Results Committee are listed below with narrative. There were 355 total deficiencies.

Total # of reports: 38
Total # of surveys deficiency free (revisits) or complaints unsubstantiated: 2

Average # of deficiencies

All = 9.34	**Complaints=3.60**
Recertification =10.28	**Inability to competize=2.00**
Extended=22.00	**Revisits=0.50**
Validation survey=10.00	

Survey Sunmary

DME- cited on all surveys we looked at. Listing: hand held shower, orthotic shoes, automatic blood pressure cuffs, glucometers, insulin supplies, medi planner etc.

Drug Regime Review- Must do all 5 components at every oasis time point (G337)

1.) Duplications
2.) Ineffective Therapy
3.) Adverse Side Effects & Drug Interactions
4.) Significant Side Effects
5.) Non compliance

PRN medications—must have frequency, and reason why the client is using it. If cream or powder must specify where they are to be put on.

Examples:

Tylenol 1000mg po prn every 6 hours as needed for pain in shoulder. Not to exceed 4,000 mg in 24 hour period.

Nystatin powder 30g topical prn every 6 hours to reddened abdominal folds

Bisacodyl 5mg po prn every 8 hours for constipation

Wounds- need to follow company policy. Weekly wound measurement with all 3 things listed
1.) Length
2.) Width
3.) Depth—must address even if no depth

Chart Correction Policy- follow agency policy. Cannot cross completely out- auditors need to be able to read what was first charted. Do not write over the top.

If you list vitals every visit then must list all vitals every visit:

1.) B/P
2.) Pulse
3.) Respiration
4.) Temperature
5.) Pulse OX- if your agency policy lists this as part of your vitals

SOC & Resumptions- Must have height and weight and if not done need a reason as to why not done

G322- Accuracy of encoded oasis data-

1.) M2250a- if you answer N/A- which identified the agency planned to follow its own parameter reporting guidelines for reporting vital signs and other clinical findings to physician—need policy of what those guidelines are.
2.) M2250b- Agency planned to place interventions related to assessing and teaching diabetic foot care on the patient's POC. This indicated the agency planned to participate in a "best practice". The patient's clinical record lacked documentation indicating the patient's physician agreed to placing this on the POC.
3.) M2250c- agency planned to place interventions related to fall prevention on patient's POC. This indicates the agency plans to participate in a "best practice". The patient's clinical record lacked documentation indicating the patient's physician agreed to fall preventions on the POC.
4.) M2250d- Agency planned to place intervention related to depression interventions on POC. The record lacked documentation to physician.

Medications M2001- if clinician checks yes- they identified a potential clinically significant medication issue and then at next question M2003 the clinician checks yes- they did contact a physician (or physician designee) by midnight of the next calendar day and complete prescribed/recommended actions—need documentation in the chart of physician clarification of the medication

G-Tags cited by Iowa Department of Inspections and Appeals

CMS description of G-tags

G-108

- Right to be informed and participate: The Client's Rights, provided in each admissions packet, indicated that the patient will be informed in advance of the care or change of care the agency planned to provide, who would provide the care and frequency of proposed visits, frequency of visits not detailed for 10 of 10 patients.

G-110

- Right to be informed and participate: agency failed to provide patients information on the agencies own advance directive policy may result in the patient putting an advance directive in place that would not be implemented.

G-114

- Agency failed to ensure patients received clear verbal and written identification of any potential out of pocket expenses.
- Patient liability for payment: Before care is initiated, the agency must inform the patient in writing if payment can be expected from federal entitlement programs, charges that will not be covered under Medicare, and the financial responsibility of the individual, agency failed to inform on seven of 10 patients sampled.

G-116

- Agency failed to provide patients with the state hotline phone number on admission.
- Home Health Hotline: patient not advised of the availability of the Home Health Hotline established by the state.

G-118

- Agency allowed an employee to work without evidence the employee was cleared by DHS to provide direct patient care, after a positive response to criminal history background check.
- Agency failed to complete required background checks, staff's hire date was 6/13/16 and the criminal background check was completed on 5/11/16.
- Compliance with laws: failed to complete criminal and dependent adult abuse background checks for 1 employee.
- Law compliance: Criminal and dependent adult abuse background checks not completed for one employee prior to hire date.
- Agency did not complete criminal background check prior to hire date.

G-121

- Agency failed ensure staff provided care in accordance with agency expectations and accepted infection control standards. Nurse put on gloves and removed clean objects from her nursing bag and did not clean them before putting them back in her bag.
- Nurse failed to wash and sanitize hands when changes gloves while performing catheter change and broke sterile technique to open supplies prior to inserting catheter.

G-132

- Governing body failed to ensure agency personnel followed federal regulations regarding acceptance of patients, provision of care, comprehensive assessments, requirement to establish a separate line of business not Medicare certified.

G-143

- Agency failed to ensure all staff providing services to a patient maintained liaison to coordinate care. Home Health Aide had been applying antifungal powder to patient and it wasn't on the care plan and the aide did not report to the nurse of the change in client condition. Patient reported new open skin areas to PT who did not pass on the information to the RN.
- LPN took verbal order, no documentation from RN to support communication between the two.
- No documentation of communication between LPN/RN or physician on new medication.
- RN did not co-sign LPN verbal order per policy. No documentation of coordination with RN.
- No documentation of contacting physician of patients refusal of care.
- No communication between wound care physician and the PCP when orders change.
- Order for SLP, no evidence of a completed evaluation in record, no follow-up between therapy and agency to make sure completed.

G-145

- 60 days physician summaries not timely and sent for review.

G-153

- The agencies professional advisory committee failed to participate in the review and establishment of the agency policies governing medical supervision, plans of care, clinical records, program evaluation and emergency care at least annually. The committee also failed to include at least one member who was either an owner or an employee of the agency.
- Professional Advisory Committee did not review agency policies prior to review by Board of Health.

G-156

- Agency failed to assure patient care followed a written physician order, assure plans were kept up to date, and to administer drugs and treatments as ordered by a physician.
- Did not follow physician ordered POC and reviewed periodically.
- POC's were created in a timely manner, provided for adequate client care and were sent for signature as required.

G-157

- Failure to complete HHA referral and then failure to provide bathing/assistance with ADL's, failure to notify Dr.
- Failure to complete all OT and PT visits, document reasons, and failure to notify Dr.
- Failure to identify and ensure patients received appropriate DME equipment/supplies.

G-158

- Agency failed to follow physician orders on the POC. Case conference summary sent to physician did not list missed speech therapy visit. SNV did not match orders on 485.
- The agency failed to provide services in accordance with the physician's orders and or failed to notify physician of changes , and to ensure an Md, Do, or podiatrist signed the POC.
- No documentation of notification to physician of missed visits.
- Order signed by ARNP not countersigned by physician.

- No notification to physician of missed home health aide visits, physician order to continue services, not to hold services.
- Agency failed to follow physician plan of care as written and notify the physician of changes in visit frequency or follow regulations regarding the use of PRN visits.
- No missed visit reported to physician.
- Acceptance of patient's POC: agency failed to provide services in accordance with the physician's orders for 5 patients: not enough aide visits; nor skilled nursing visits, clinical orders lacking for treatment of blisters; lacked physician's orders for home health aide to apply TED hose.
- Agency failed to provide reasons for additional PRN visits for multiple patients, or what circumstances PRN visits to be made--multiple patients.

G-159

- Failure to maintain complete and accurate POC. Not all DME equipment in the home listed on the 485. POC lacked goal for medication compliance.
- Documentation not included on plan of care, e.g. skin care, TED hose, no specific parameters and no notification to physician, medication failed to note specific eye drops, no differentiation between "skilled" and "non-skilled", there all must follow Medicare conditions of participation regardless of payment source, patients receiving non-skilled services used Medicare conditions of participation.
- POC's lacked accurate information regarding required treatments, nursing care and medications.
- Not all DME listed on POC.
- Not all DME listed on POC; client told surveyor of visits to bar indicating non-homebound status; agency issued non-coverage notice 4 days after surveyor visit; another client told surveyor they left home almost daily while the agency had "homebound" status listed on POC.
- Plan of Care lacked route of meds, frequency of prn meds, identification of DME such as tub grab bars, reacher, adult diapers, commode, Hoyer lift.
- For nine of 10 patients sampled: no frequency for medication usage, no route to take medications, no frequency of PRN medication usage, no strength of medications identified, not d/cing medications not used; DME: failure to identify grab bars, toilet insert, hand-held shower, lift chair, walkers, cane, slip mat CPAP, TED hose, pill cutter, medbox, BIPAP; agency failed to provide order for aides to apply TED hose; no orders for blood sugar parameters.
- Agency failed to ensure the accurate completion of all components of POC. Hydrocodone set up in pill planner differently than was ordered on the pill bottle. Not all of the DME equipment in the home was listed on the 485.
- Plan of Care lacked circumstances under which discharge would occur for therapeutic reasons; DME not listed in care plan (pill cutter, glucometer, blood pressure cuff, etc.; PRN medicine without reason for use; medication not specific for frequency of use.
- Prn medications on plan of care did not have specific parameters for frequency, route, care plans not revised to remove "new" designation when appropriate, not all DME listed on POC.
- Medication lacked route.
- Failed to have accurate current POC.
- Lacking DME in the home.
- Aide care plan lacked specificity, and duration or frequency of visits.
- DME not listed in POC or indication of any changes.
- No update to medication profile for changes.
- Failed to address mental status or allergies per regulation.
- Lacked specific orders for wound care.
- Discharge plan lacked specific reason under what circumstances patient would be discharged.

- Plan of care: 10 of 10 patient care plans samples and survey did not completely list all DME and medications.
- Medication wrongly identified in POC, no order for how often of another medication or where to place eye drops.
- Plan of care: not accurate for nine of 12 sampled patients: failed to list hand-held shower, mediplanner, disposable incontinence products; failed to list how often patient was to take diuretic, etc.
- Plan of Care: agency failed to have an accurate, complete and updated POC for five patients at the start of each 60 day certification period; most violations included undocumented DME.
- Plan of Care: numerous instances of medications listed but no dosage or schedule included; hand-held shower, magnifier/reader and PERs system in house but not on POC.
- Agency failed to ensure the accurate completion of POC. Not all DME equipment was listed on the 485. (Grab bars, shower bench, incentive spirometer) patient pill planner not filled as medications were prescribed. PRN medications did not have a frequency or reason for use. POC lacked documentation for Rehabilitation potential.
- Agency failed to maintain complete and accurate POC with current orders. Not all DME equipment listed. POC listed PRN nursing visit but did not specify when it would be used. POC did not list all the medications client was using. PRN medication did not list why client was using it.
- Plan of Care: agency failed to ensure physician-ordered POCs contained accurate, complete and up-to-date information for three of three sampled residents; order for rash cream failed to identify frequency, failed to include hand-held shower, scales and reachers as DME; discharge plan failed to identify circumstances for discharge.
- Plan of Care: Multiple instances of POC not including DME, incontinent briefs and glucometer.
- Plan of Care: order failed to identify a reason for use of over the counter medicine; failed to identify a reason for a topical analgesic; POC contained inaccurate statement "no changes to POC" when part of it had been crossed out meds discontinued.
- Agency failed to ensure the accurate completion of all components of the POC. PRN medications did not have frequency, lotion lacked where to apply it to. Medication did not match physician orders. POC lacked a discharge plan. Not all DME items are listed on the POC.
- Agency failed to ensure accurate completion of all components of the POC or failed to make sure it contained current and accurate information. POC did not list all of the DME products in the home. Medication orders for PRN medications did not have frequencies or location of where to apply the creams.
- Plan of Care: patient to receive Tylenol Arthritis by mouth every 8 hours; surveyor found meds in the home but patient said haven't used for "several years." House had DME items that patient hadn't used "for several years" but was still listed on POC; no notation for amount of sliding scale insulin. "Activities permitted" section of POC left blank.
- Lack of evidence completion of background check prior to start of work for Aide.

G-163

- POC's were not reviewed and updated every 60 days.

G-165

- Agency failed to ensure staff obtained physician orders for treatments. Clinical record lacked a physician order for treatment that nurse had already performed.
- POC lacked physician orders for medications, changes to wound care.
- Agency failed to assure all drugs and treatments were administered by agency staff only. Client had oxygen in the home with no order for it.

- Nurse flushed client's ears without physician orders; no order for application of triple antibiotic ointment to head laceration.
- Failure to ensure proper wound care orders placed on plan of care and not following physician orders re: wound care.
- Prn medications and medications used for wound care were not added to the POC.
- Lacked documentation per physician order i.e. ace wrap, SN stated TED hose, no order for weight measurement for each visit.
- Conformance with physician's orders: Clinical record lacked documentation the agency nurse wrote an order for wound care to patient's right and left posterior ankle wounds per physician's orders.
- RN failed to report new open area to physician and secure treatment orders.

G-166

- RN did not co-sign LPN verbal order per policy prior being sent to physician RN failed to secure orders for and also follow Dr orders for finger stick INR tests.
- Lacked physician order to place medications on hold.

G-168

- Agency failed to ensure its nurses provided care in accordance with a physician order POC and that the nurses adequately reevaluated the patient's status, and that the RN coordinated information between the case managers, hha, and other agency staff.
- Nurses did not provide care in accordance with physician's orders.
- No d/c plan on S.P on numerous occasions; DME inspirometer, scales, lift chair, TED hose, reacher, etc; no order to resume care after hospitalization, care plan lacked reason when and why to give Ibuprofin.
- Failed to adequately assess patient for changes.

G-170

- Failure to provide care in accordance with a physician order. Skilled visit not lacked evidence of nurse taking a respiration. Recert assessment lacked documentation of diet/nutrition and mental status, respiration rate, current blood sugar level.
- Nurses did not adhere to visit frequency on POC or follow orders for assessment and treatments.
- Haldol injection not administered every 21 days as ordered; no orders for Risperdal being placed in medication cassette weekly, Invega injection not administered one time monthly as ordered; capillary refill rate not assessed as ordered by physician; no documentation nurse completed med set up as ordered.
- No documentation nurse assessed client's medication compliance; two visits lacked documentation of ordered blood glucose levels or weight; oximetry readings not documented; ordered diabetic foot care instruction not documented; lack of documentation for daily SN visits ordered for wound care; wound measurements not documented.
- Failed to complete assessment for ordered vital signs at every visit.
- Failed to show evidence of diabetic education per physician orders.
- Failed to measure and complete full wound assessment.
- No weight obtained as ordered; no documentation nurse reviewed weight log or assessed mental health status at each visit as ordered.
- Weight not assessed at each visit as ordered for client with diagnosis of failure to thrive; order to assess skin status of lower extremities at each visit and nurse did not remove compression stockings to examine legs.

- SN went above scope of practice to notify physician of changes to BG results until 7 days after change occurred on several occasions against signed physician parameters.
- Skilled nursing services not provided for five of nine patients sampled; lack of documentation showing patient's "coping" status, lack of documentation for a fall and pain assessment, failed to measure weight, etc.
- No documentation of contacting physician of patients refusal of care.
- Erroneous documentation on wrong leg wound, no assessment performed on correct leg.
- Skilled nursing services: RNs failed to provide physician-ordered services for 8 of 11 patients; failed to document drawing up patient's insulin, notes lacked documentation of weight gain, lacked documentation nurse had checked GT balloon, etc.
- Skilled nursing services were not adequately provided to four of 11 patients sampled: orders for four times daily blood checks and insulin injection not completed, weight gain of five pounds not reported to physician, did not check for lower extremity edema.
- Agency failed to provide skilled nursing services in accordance with the physician orders. Patient's clinical record lacked documentation that a bowel routine was performed. Clinical record lacked documentation that wound care was performed as ordered. Clinical record lacked documentation that IV rocephin was administered as ordered. No record that the nurse took weights, or set up patient’s pill as ordered.
- Skilled nursing services: failed to provide for three patients; nurse failed to document wound status regularly for patient using a wound vac, vitals, and elimination; another patient failed to have nurse document pain level.
- Skilled nursing services: POC for infant included oral care, tracheostomy, range of motion, daily measure blood pressure; notes lacked documentation of oral care once daily, trach, etc.
- Skilled nursing services: Jackson Pratt bag was flushed with saline by RN, this was not on the POC; drains were flushed with saline to clear, was not on POC.
- Plan of Care: POC not current for eight of 10 sampled patients; shower chair, glucometer, failed to state reason for inhaler, software didn't have filed for reason for PRN meds, weigh scale as DME, etc.
- Failed to use stethoscope to assess L.S. and ask about presence of cough; failed to assess for urinary tract infection and respirations; not physicians order that oxygen saturation levels be assessed, no weight measures doe; failed to remove socks and shoes to assess edema.

G-172

- Agency failed to regularly reevaluate the patient’s status. Wound measurement failed to have depth.
- Nurses failed to re-evaluate patient status and respond to need for care plan changes.
- No depth recorded for wound assessment (five times) and measurements (four times).
- No wounds measurements documented.
- Nursing assessment failed to establish a baseline status for all areas assessed by nurse at each visit; no interventions documented for elevated blood glucose readings.
- Failed to reevaluate patient's status; lack specific wound care/assessment/measurement policy; inconsistent documentation (presence of wound); lacked documentation of skin assessment, and wound measurement/depth.
- No wound measurements documented per order.
- No interim order to change wound care frequency.
- Agency failed to ensure the RN routinely reassessed the status of client conditions. Nurse only had 2 measurements documented on wound but did not identify if it was length or depth. Visit note missing wound measurements.

- Duties of the registered nurse: agency failed to ensure registered nurses adequately reevaluated patients' status and respond to care for two patients; failed to document wound care assessments.
- Agency failed to ensure the agency's nurses adequately reevaluated the patient's status and response to care. No wound measurements on wound, client who was diabetic did not check BS for a week so nurse could not report to physician if out of range and did not check one while she was at the home.
- Duties of the registered nurse: RN failed to adequately reevaluate 2 patients status and respond to care for skin breakdowns; lack any measurement or description of wound, including depth.
- Agency failed to ensure the nurses adequately reevaluated the patient's status and response to care. No wound measurement for a wound client.
- Duties of the registered nurse: agency policy entitled "wound care" should include documentation at least weekly measurement of width and depth of wound; documentation included width but not depth.
- POC lacked documentation of wound care provided by RN, and depth of wound measurement.
- Duties of the registered nurse: the agency failed to ensure the registered nurse comprehensively and routinely reassessed the status of three of 11 patients, wounds not measured, no weight measures recorded, etc.
- Wound care ordered every 3 days not completed; wound not measured at each SN visit.

G-173

- Duties of the registered nurse: registered nurse failed to review plans of care for three of five patients.
- Staff failed to identify in-home medications on plan of care, and revise plan of care accordingly.
- Medication orders listed on POC and meds used in home did not align; no clinical orders for use of oxygen.
- Agency did not follow Medicare Conditions of Participation for all clients as required since there was no separate line of business for non-skilled care.

G-176

- Failure to coordinate other agency services and/or communicate the patient's status with the physician. The clinical record lacked physician notification that client wanted to start IV rocephin. Clinical record lacked documentation of notification of weight gain greater than 5lbs.
- Agency did not report client non-compliance with anti-psychotic medications; other parenteral medications not administered by nurse as ordered for psychiatric diagnosis; nurse added Acetaminophen to med planner without physician orders.
- Duties of registered nurse: physician's orders included contacting him if patient gained more than five pounds in one week, clinical record lacked documentation weight was taken; OT evaluation completed four days after the agency policy for completion Nurse unable to administer Vitamin B12 as medication not in the home but no documentation that the nurse notified the physician.
- HHA notes not incorporated into the client record in a timely manner and as according to agency policy and procedure; failure to report client blood glucose levels of 566 and 509 to physician and POC did not include specific reporting parameters for blood glucose readings; RN failed to review HHA notes; no orders to apply Biofreeze by HHA; incomplete documentation of PT services; HHA did not complete all tasks ordered and assigned; No orders for resumption of SN, HHA, PT and OT after client hospitalized.
- Duties of the registered nurse: RNs failed to coordinate care with physician for two residents with skin breakdown.
- Incorrect OASIS assessment completed when client was hospitalized; agency did not have policy for reporting blood sugar readings (300-500) to physician; weight gain of 3# in 4 hours not reported to physician.

- Nurse did not notify physician when systolic BP, respirations or pulse readings exceeded reportable limits.
- Very late received therapy notes, client had already been discharged from agency services.
- Aide notes lack documentation of why task was not performed. SN documented on supervisory visit, aide follows care plan.
- No notification to physician of significant changes regarding weight loss or gain, failed to revise medication plan of care for additional medications in home.
- No order to place medication on hold.
- Lacked notification or documentation of high BP to physician.
- Duties of the registered nurse: agency failed to ensure registered nurse failed to communicate the patient's condition to the physician for 4 of 11 patients samples; physician was not notified of patient's low pulse readings and elevated blood sugar and edema.
- Duties of the registered nurse: clinical record lacked documentation that physician was informed and aware of the patient's need for analgesic 4 times a day routinely; instead of on an "as needed" basis as ordered by plan of care.
- Duties of the registered nurse: failed to coordinate care provided by the home health therapists, and failed to report patients' condition to physician for six patients.
- Failure to complete HHA referral and then failure to provide bathing/assistance with ADL's, failure to notify Dr.
- Failure to complete all OT and PT visits, document reasons, and failure to notify Dr.
- Failure to notify and ensure patients received appropriate DME equipment/supplies.
- RN did not follow thru on obtaining orders for and completing medication set up.
- RN failed to administer injectable medications as ordered monthly and did not report to Dr in a timely manner and as per policy.
- RN failed to secure orders for and also follow Dr orders for fingerstick INR tests.

G-210

- Agency failed to document whether basic skills competencies were evaluated in a lab setting using a pseudo patient or in a home setting while being performed on an actual patient.
- HHA written exam did not include supervising RN's signature; competency documentation did not specify which type of shampoo was performed.
- HHA training documentation: Agency failed to document whether basic skills and extra skills competencies were evaluated in a laboratory setting using a pseudo patient or in a home setting using an actual patient for 6 of 7 patients.
- Failed to identify where aide competencies were performed.
- HHA training documentation: home health aide must show general competence in 13 general basic areas, HHA provided showers without competency.

G-212

- Personnel files of sampled hha lacked documentation of observation of the task by a RN in the assigned task area.
- No documentation of aide training and competency for use of EZ stand lift, application of TED hose.
- No aide competency evaluation documented for application of TED hose.
- No documentation of training and skills competency for 3 HHA's for tasks requiring skills that exceed basic level of home health skills.
- Failed to complete competencies on extra tasks for HHA prior to performing. i.e. shaving, hoyer lift.

- Competency evaluation & in service training: personnel file lacked documentation of observation of a care task by a registered nurse to determine competency prior to assigning the home health aide to care for a patient requiring home health care services.
- Documentation lacking that home health aides were overseen by an RN before they were able to work independently.
- Agency failed to document seven of seven aides assigned to perform tasks requiring extra skills exceeding the level of basic home health skills had documented evidence of competency by an RN.
- Competency evaluation and in-service training: agency failed to ensure an agency RN evaluated and documented home health aide competency in the performance of "extra" skills which exceed the level of basic home health aide skills, prior to assigning those home health aides to perform those tasks independently for two of four sampled home health aides; aide transferred patient with a Hoyer lift, and application of Aquaphor.
- Agency failed to ensure competency of home health aides exceeded level of basic skills, failed to ensure competency to use stocking, sponge toe, velcro compression stocking.
- No training or competency documented for HHA who were assigned to help client with a mechanical soft diet.

G-214

- Agency failed to complete annual performance evaluations for three home health aides.
- Competency evaluation and in-service training: agency failed to perform annual HHA performance evaluations on three of six sampled HHAs.
- Performance reviews not completed annually on all aides.

G-218

- Agency failed to ensure a registered nurse performed direct observation of home health aide performance of all required basic home health aide skills on a patient or pseudo patient in order to determine competency.
- No documentation of competency of basic home health skills for several HHA's prior to assigning client services.
- Competency evaluation and in-service training: agency failed to ensure RN performed direct observation of all required basic home health aide skills on a patient or pseudo patient.
- Failure to identify where aide competencies occurred.
- HHA did not assure that aide performed assisting client with use of bedpan in a live client, rather than lab setting.

G-224

- Assignment and duties of home health aide: agency failed to provide individualized and specific written instructions from a registered nurse, aide assignment for POC lacked instructions for the aides to apply compression stockings or knee brace, aide assignment lacked specific instructions on what specific type of bath to offer (sponge v full).
- Assignment and duties of home health aide: agency failed to provide individualized and specific written patient care instructions from a RN to home health aides for two patients.
- Assignment and duties of home health aides: RN failed to provide written and specific instructions to three home health aides; aides did not receive a copy from the RN but were expected to take notes on what she said.
- Lacked individualized and specific written instructions on care plan for cream to apply to skin, e.g. type of cream.
- No written plan of care and assignment for HHA's providing care for private pay patients.

G-225

- Agency failed to ensure all home health aides provided services according to the home health aide written assignment. Aide notes did lacked a reason why they did not complete certain tasks.
- Home Health Aide plan directed the hha to provide catheter care which was not being done and the nurse was not notified.
- No documentation of contact between aide and nurse when assigned tasks not completed
- Home health aide care plan not followed and no evidence RN contacted for prior approval of new tasks requested by patient, tasks not assigned but performed by aide, lack of documentation and failure to perform tasks.
- Assignment and duties of home health aide: agency failed to ensure home health aides provided services according to the home health aide written assignment for five of seven patients.
- Assignment and duties of home health aide: if patient requests aide to perform a task that is not included in POC, the aide will call the office for guidance, compression stockings were put on patient by aide, clinical record lacked documentation that aide called office RN to ask about sock installation.
- Assignment & duties of home health aides: failed to provide services per written assignments, failed to weigh patient during each visit.
- Assignment & duties of home health aides: home health aide notes lacked documentation that aide shampooed patient's hair and applied lotion per care plan; aide complete a number of additional tasks without notifying the nurse and obtaining approval to change aide assignment.
- Aide failed to document why he/she failed to complete an assigned task; lacked documentation aide assisted patient with hair shampoo.
- Assignment and duties of home health aide: no documentation home health aides contacted RN for instructions regarding shampooing patient.
- Assignment and duties of home health aides: HHAs failed to provide services per written assignments for five of nine patients; aides didn't contact nurse for approval of additional services requested by patient.

G-226

- Medical records: accurate and timely additions to clinical record not made for eight of 12 patients.
- Clinical record: not complete and accurate for six of nine patients sampled; staff electronic signatures not activated.

G-229

- Supervision: agency failed to complete home health aide supervision at least once every 14 days for 2 employees.
- Supervision: RN must make on-site visit to patient's home no less frequently than every two weeks for two of eight patients sampled.
- Agency did not provide aide supervision at least every 14 days.
- Aide supervised less than 14 days related to private pay and no separate agency for them.

G-230

- Supervision: agency failed to ensure registered nurse completed home health aide supervision at least every 60 days while observing the home health aide present and provide direct care for one patient.
- Supervision: agency failed to provide registered nurse home health aide supervision visit at least every 60 days.

- Supervision: Registered nurse did not make supervisory visit to home health aide worksite at least every 60 days.
- Agency did not provide supervision of "aide only" services every 60 days.
- RN did not supervise aide services at least every 60 days.
- Lacked documentation of a direct supervisory visit of aide in timely manner >60 days.
- Aide supervision less than 14 days.
- HHA supervision not provided every 30 days to patients with health aide only service.

G-236

- Agency failed to maintain up to date patient clinical records, including legible, clear and accurate documentation. Staff did not follow agency policy when making corrections to charting. No wound sheet in patients chart and no measurement on visit note for wound. Home health aide notes not put in clients charts timely. Physical therapy notes not in charts timely.
- Clinical notes and other documentation not completed timely in accordance with agency policy.
- Agency did not follow policy for scanning medical records in a timely manner.
- Agency failed to maintain accurate and complete clinical records, failed to ensure which/when RN gives choice, charting complete but not measuring and charting weight changes, staff "did weights and vitals but failed to document.
- Clinical documentation was not kept up to date or filed in the patient record in a timely manner.
- Aide documented completing tasks that the client did independently.
- Aide notes not addressing care plan and why not completed.
- Unapproved usage of abbreviations.
- No method of how temp was taken, patient's position with BP. Many areas of assessments left blank without supporting documentation.
- Record showed no HHA documentation filed within the 7 days per policy.
- Late completion of documentation for visit by SN.
- Lacked date of signature to determine correct day of visit.
- Clinical records: failed to maintain for seven of 11 patients; agency policy required current entries, many were late, lacked documentation of medication set-ups.
- Clinical records: agency failed to maintain accurate clinical records for six of 16 patients; clinical record wrongly identified patient as female on both the patient profile and plan of care.
- Agency failed to maintain patient clinical records with complete and accurate documentation and correct errors per agency policy. Home health aide failed to document the care provided. Electronic charting lacked an electronic signature and remained unlocked or 117 days.
- Clinical records: entries into electronic system lacked electronic signature and date of signature, did not list what oxygen equipment care tasks were completed for each visit, incorrect entries regarding start dates of care.
- Agency did not keep timely client medical records nor correct errors according to agency policy.
- Clinical records: patient's clinical record did not contain current POC, nor two physician's verbal orders, both dated Nov. 5.
- Agency failed to maintain patient clinical records with legible, accurate, up to date and timely documentation signed and dated by the staff member. Chart was missing PT notes.
- Employees did not follow chart correction policy on charting. Agency delayed more than 48 hours in starting patients care with no explanation of why.
- Agency failed to maintain clinical records with legible, accurate, up to date and timely documentation signed and dated by the staff member.
- Clinical records: performance of "incidentals" (removing trash, dusting, etc.) was not recorded specifically enough, e.g. trash removed was recorded as "incidentals performed."; documentation

of PT failed to list exercises, aides not charting that they had been putting compression socks and knee braces.

- Agency did not have policy prescribing time frames for completion of electronic health records
- Clinical records: date of referral form, date left blank; clinical record lacked home health assignment or home health aides notes; physician's order for patient was filed in another patient's file.
- Clinical records: five cases of nurses not signing electronic medical records for purposes of attestation and authorship; entry had X written through it which obliterated the original entry; incorrectly dated entries.

G-239

- Protection of records: home health aide notes sat on a pile on aides desk, were unsecured and not entered into HIT system.

G-243

- Agency failed to do annual evaluation of program and policies.

G-244

- No QA/QI data reported to Professional Advisory Committee regarding chart audits.

G-245

- No information found in Professional Advisory Committee minutes that an evaluation of the agency's program was conducted since 2015.

G-246

- Agency failed to report of the Annual Program Evaluations to the Governing Body, and failed to document guidance provided back by the Governing Body.
- BOH did not act upon an annual agency evaluation.

G-248

- Policies and procedures not reviewed annually and updated.

G-250

- Agency failed to have the appropriate health professionals conduct quarterly clinical record reviews of the care provided to patients. RN's are required to review skilled nursing services, OT must review OT and OT assistant services, PT must review PT and PTA services and Speech Therapy must review SP services. Clinical audit form lacked signature of the person who performed the quarterly review, and lacked the date.
- Clinical record audits not performed quarterly on all disciplines.
- Failed to do quarterly clinical record audits.

G-303

- Clinical records: agency failed to inform attending physician of the availability of a patient's discharge summary.
- No discharge summary notice to physician.
- Discharge summary or notice not sent to physician.

G-321

- Agency failed to transmit OASIS data within the required 30 days.

- Encoding OASIS data: agency failed to transmit OASIS data within 30 days of the OASIS M0090date (completion date of the assessment) for five of seven samples patients.
- OASIS data not transmitted within 30 days for two clients.
- OASIS data not transmitted within 30 days M0090 date for six of eight patients.

G-322

- Agency failed to transmit accurate OASIS data for adult patients. M2250A- included a documented response of "N/A" which identified the agency planned to follow its own parameter reporting guidelines for vital signs and other clinical findings to the physician; ROC assessment M2250f- included documentation the agency reported inclusion of interventions to assess for pressure ulcers. The agency stated they had contacted the patient's physician who was in agreement but the clinical record did not include collaboration with the physician. M2000, the nurse documented a problem with the reconciliation of the patient's medications. At M2002 the nurse documented receiving a response from the physician but the clinical record lacked any documentation to show this. Agency failed to perform the drug regiment review in a complete and accurate manner.
- Agency claimed credit for OASIS best practice not ordered by physician or did not have practice parameters.
- Best practice status claimed on OASIS without reporting parameters in place.
- Transmission of inaccurate OASIS data, lack of interventions in plan of care, agency used "best practices" inclusion policy for protocols signed by physician for all patients admitted to agency.
- No orders in POC to perform diabetic monitoring.
- No established parameters for clinical reference to notify physician.
- Failure to complete required OASIS data items.
- No policy for reporting vital signs parameter guidelines and reporting to physician; reporting inaccurate dates to state; no orders for patient specific parameters.
- Accuracy of encoded OASIS data: inaccurate coding for four of nine patients sampled: claiming data is part of "best practices" when it's not.
- Accuracy of encoded OASIS data: agency appeared to intend to participate in CMS "best practices" program and took credit for it using inaccurate information e.g. vital signs.
- Initial assessment visit: agency failed to provide initial assessment visit within 48 hours of receipt of a referral from a physician within 48 hours of the patients' return home or from an inpatient facility for two of eight patients.
- Accuracy of encoded OASIS data: patient's clinical record lacked any documentation indicating the agency used a standardized, validated pain assessment tool by the end of the fifth day following the patient's start of care; agency transmitted "best practice" data that it did not actually participate in.
- No vital signs parameters in place; lack of education for diabetic foot care and fall interventions
- Accuracy of encoded OASIS data: three of five sampled patient data was entered into system as "best practices" when it was not.
- Agency failed to transmit accurate OASIS data. M2250A- the agency planned to place vital sign and other clinical finding parameters for reporting on the POC. This indicated the agency planned to participate in "best Practice". The clinical record included physician orders dated 10 days after the completion for him SOC.

G-322

- Agency failed to transmit accurate OASIS data for adult patients. M2250A- included a documented response of "N/A" which identified the agency planned to follow its own parameter reporting guidelines for vital signs and other clinical findings to the physician. The agency had no parameter guidelines. M2250c- the agency planned to place interventions related to fall

prevention on the patient's POC. This indicated the agency planned to participate in "best practices". The patient's clinical record lacked documentation indicating the patient's physician agreed. M2250b- the agency planned to place interventions related to assessing and teaching diabetic foot care on the patient's POC, this indicated the agency planned to participate in 'best practices' , the patient's clinical record lacked documentation indicating the patients physician agreed to placing this on the POC.

- No parameters for vital signs on POC, but this was coded as a "best practice" in the OASIS; no standardized pain assessment tool utilized, but coded as "best practice"; nurses notes reveal client had non-pitting edema but OASIS was coded as "no signs of CHF", no evidence that the agency collaborated with physician on falls and depression intervention, but claimed best practices in these areas.
- OASIS data accuracy: inaccurate for three of five patients; agency did not have guidelines for vital signs reporting.

G-323

- M2250a answered yes, without specific parameters orders by physician.

G-330

- Agency failed to assure a RN completed thorough, timely and accurate SOC assessments and that the nurse completed a DRR that was thorough. That the RN completed Recerts, and D/C assessments timely.
- All required OASIS assessments not completed within required time 5/60/48hrs.
- Failed to provide initial assessment with 48hrs receipt of referral.
- Not all clients assessed within 48 hours, not all comprehensive assessments completed in 5 days, not all clients received an accurate drug regimen review; not all assessments completed timely, resumption of care assessments not completed within 48 hours.
- Comprehensive assessment of patients: agency did not complete thorough, accurate start of care comprehensive assessments within five days of admission; did not complete a drug regimen review, resumption of care assessments within 48 hours.

G-332

- Initial visit was not completed within 48 hours of receipt of Dr's order, Dr was not notified, no reason documented.
- Initial visit was not completed within 48 hours of receipt of Dr's order, Dr was not notified, and reason stated was no staff available.
- Initial assessment not completed within 48 hours of referrals
- Initial assessments not completed until 5 days after referral; one client referral received 9/7, insurance authorization received 9/23, but client not seen until 9/26 with no documentation of communication with physician who made the referral.

G-334

- Agency failed to ensure accurate completion of all components of SOC comprehensive assessment within required time frames. SOC oasis.
- Comprehensive assessments not completed timely.
- No documentation that nurse contacted physician regarding medication issues identified during drug regimen review with 24 hours of completion of review.
- Failed to complete OASIS for SOC within time frame required.
- M2250a again answered yes for same reason no matter what method of payment i.e. private insurance.

- Federal guidelines defining separation of a certified agency and a separate uncertified entity (business) the agency did not meet all requirements to separate the "certified home health agency" from the "home care aide/homemaker program".
- Completion of comprehensive assessment: agency failed to provide comprehensive assessment of four patients immediately, but no later than five calendar days later.
- Agency failed to complete all pertinent components of the SOC assessment within the required time frame. OASIS not locked by day 5. Clients chart had no medication review on SOC.
- Completion of comprehensive assessment: Height and weight not recorded and if so then reason measurements not taken.
- No patient-specific parameters for vital signs for notification of physician, aide care plan incorrect compared to skilled nursing assessment, DME reported but not seen in home by surveyor, incorrect information in assessment compared to nursing assessment.
- Completion of comprehensive assessment: care start date of Jan. 13, assessment completed Jan. 19 (one day late); assessment lacked documentation of height and weight, clinical record lacked evidence the physician was contacted regarding vital signs parameters.
- Completion of the comprehensive assessment: agency failed to provide comprehensive assessment immediately after start of care but not more than five calendar days later for five of seven patients.
- Comprehensive assessments not completed timely on 5 clients.
- Completion of comprehensive assessment not completed within five days after start of care for three of 10 patients samples.
- Completion of comprehensive assessment: not completed immediately or within five days of commencement of care for one resident.
- Reported patient had Medicare but only had Medicaid; no agency clinical guidelines re; parameters; physician notification for nurses to reference vitals not done; no diagnosis of diabetes listed; inaccurate information for diabetic teaching; nurse did not document all necessary physical assessment information in comprehensive assessment.

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

- Agency failed to do DRR with all components addressed. Agency did not address ineffective drug therapy and compliance with drug regimen.
- Incorrect medications/dosages, no documentation of review identifying discrepancies.
- Medication discontinued in POC, however patient continued to take.
- Failed to complete drug regimen review, no date on SOC assessment, therefore never completed
- Drug regimen review: three of five patients sampled showed lack of evidence the nurse reviewed for duplicate medications, ineffective drug therapy, significant drug interaction and significant side effects.
- No order to place medications on hold.
- Failed drug regimen review.
- Medication review did not address potential adverse effects etc for medication list.
- Incomplete medication regimen review for OTC supplements, other medications that are in cupboards, drawers or anywhere else in the home.
- Agency failed to ensure the accurate completion of all required components of DRR completed. Clinical record lacked order for one medication. Pill bottles did not match physician order for medications.
- Nurse did not review medication bottles that patient set up and revealed numerous medications not being taken correctly, agency failed to ensure patient taking medications correctly numerous times.

- Drug regimen review: agency failed to include all prescription and over the counter medications when completing drug regimen reviews for five of eleven patients, patient taking vitamin D that was not on drug regimen review.
- Agency failed to include all prescription and over the counter medications taken by the patient when completing the DRR.
- Drug regimen review: incorrectly done for three of 12 patients sampled, medications survey found in patient's house not on drug regimen review sheet.
- Agency failed to include all prescription and over the counter medications taken by the patient and failed to identify discrepancies by reconciling the medications the patient had.
- Drug regimen review: policy that drug regimen review be conducted every 60 days was not followed.
- Drug regimen reviews not completed with all comprehensive assessments.
- Drug regimen review: outdated meds not destroyed, over the counter meds in sight but not part of drug regimen review.
- Drug regimen reviews not completed with all comprehensive assessments for four of four patients.

G-338
- Inconsistent documentation on wound assessment.
- Lacked significant change in condition follow up assessment following fall, with injury.

G-339
- Update of the comprehensive assessment: not done during the last 5 days of the 60-day cycle for six of seven sampled patients.
- Recertification assessment not electronically signed within required time frames.
- Comprehensive assessments for recertification of services not conducted in the 56-60 day window.
- Update of the comprehensive assessment the last five days of every 60 days beginning with care start date.
- Required pain assessments not completed.
- Recertification not performed between 56-60 day window, lacked date of signature.
- Recertification visits, and completion of POC not timely, falling into the next episode of care.
- Agency failed to accurately complete recertification assessments in a timely manner. Assessments not signed by end of 5 day window. Lacked documentation of height and weight and nutritional status.
- Recertification assessment not done in less than 60 days, and completion in less than three days per agency policy; recertification visits performed too early (11 days).
- Incomplete documentation of respiratory/temp assessments.
- Recert late for direct supervision of aide x 8 days.
- Recert exceeded end of period for completion.
- Incomplete documentation provided concerning recertification in OASIS.
- Update of the comprehensive assessment was not done the last five days of every 50 day cycle for four of nine sampled patients.
- Agency failed to accurately and thoroughly complete recertification in a timely manner.
- Agency failed to ensure accurate completion of all pertinent components of the recert assessment between days 56-60. Height and weight were left blank.
- Update of the comprehensive assessment: agency failed to recertification period ensure accurate completion of all pertinent components of the recertification comprehensive assessments between

days 56 and 60 of each patient requiring recertification assessment: weight not measured and if not, why.
- Update of the comprehensive assessment: agency failed to ensure accurate recertification comprehensive assessments were completed between days 56 and 60 of each certification period for four of eight residents.
- Update of comprehensive assessment: agency failed to ensure accurate and timely completion of all pertinent components of the recertification comprehensive assessment between days 56 and 60 of each certification period for five residents.
- Update of the comprehensive assessment was not done the last five days of every 50 day cycle
- Agency failed to complete recertification of comprehensive assessments on three of seven patients samples; recertification lacked documentation of wound length and depth and oxygen saturation levels.
- Update of the comprehensive assessment: agency failed to recertification period ensure accurate completion of all pertinent components of the recertification comprehensive assessments between days 56 and 60 of each patient requiring recertification assessment.
- Update of the comprehensive assessment not complete during the last five days of a 60-day cycle for six of nine patients sampled.

G-340

- Agency failed to ensure accurate completion of all components of resumption of care within 48 hours of agency's knowledge of return home.
- Agency failed to complete Resumption of care within 48 of return home or knowledge of return home.
- Update of the comprehensive assessment within 48 hours of the agency's knowledge of the patient's return to home.
- Agency did not complete comprehensive reassessment upon discharge from hospital within 48 hours.
- Update of the comprehensive assessment: not uploaded to OASIS with 48 hours for one resident.
- Update of the comprehensive assessment: 2 assessments not completed within 48-hour deadline.
- Update of comprehensive assessment: agency failed to ensure accurate completion of all pertinent components of the resumption of care comprehensive assessment within 48 hours of the patient's return to home.
- Update of the comprehensive assessment: agency failed to update comprehensive assessment within 48 hours of a patient's return to home for one of two sampled residents.
- Agency did not collect OASIS data on 'home health aide only" clients.
- Agency failed to complete assessment within 48 hours with knowledge of a d/c.
- Assessment not completed within 48 hours of return home from hospital stay.

G-341

- Agency failed to complete timely transfer or discharge assessment.
- Agency did not complete timely discharge and transfer OASIS.
- Update of the comprehensive assessment: Failed to update OASIS with assessment information within 48 hours of a patient's return to home.
- Update of the comprehensive assessment: agency failed to ensure timely completion of the discharge comprehensive assessment within 48 hours of patient discharge.
- Transfer assessment not completed within 48 hours of knowledge of transfer
- Transfer/discharge assessment late on completion.
- Discharge assessment never completed related to no documentation of wound section was not filled out.

G-342

- Electronic health record not allowing full integration of OASIS info.
- Agency failed to do annual evaluation of program and policies.
- Agency's software system did not allow full integration of the OASIS and the comprehensive assessment.