Iowa Center for Home Care
HHA Survey Review G-Tags
2nd Quarter 2018

Survey type: 12 recertification surveys (1 deficiency free), 0 extended (0 deficiency free), 3 complaints (1 deficiency free), 4 revisits (0 deficiency free) recently reviewed by the ICHC Survey Results Committee are listed below with narrative. There were 99 total deficiencies.

Total # of reports: 19
Total # of surveys deficiency free (revisits) or complaints unsubstantiated: 2

Average # of deficiencies

All = 5.21	**Complaints = 39**
Recertification = 5.58	**Inability to competize = 0**
Complaint/Extended = 0	**Revisits = 1.66**
Validation survey = 0	

Survey Summary and be sure to see Compliance Tips at the end

G-Tags cited by Iowa Department of Inspections and Appeals

Old CMS description of G-tags

New G tags

G-145

- Coordination of Patient Services: Failure to keep physician appraised of patient status and progress towards goals. No 60-day summary provided to physician.

G-158

- Agency did not recertify VA patients every 60 days due to the VA only paying for a nurse to do a visit every 6 month.
- No ROC order obtained.

G-159

- Failure to maintain complete and accurate POC: No discharge plan as required by regulation; No documentation to include catheter and related supplies; plan lacked physician approved dosage of medication (ex Senna).
- Hand held shower and shower chair not on 485. All meds used by patient were not on 485. Rehab potential not listed on 485. Oxygen not on the med profile. Incont supplies (briefs and disposable bed pads were not on the 485. Bp cuff, heating pad not on 485.

G-172

- Duties of Registered Nurse: Failure to reevaluate the patient's status for unidentified worsening of pt. condition, inappropriate treatments and unmet home health care needs. Medication list did not reflect orders that had changed dosages of medications, medications were not available and clinical record lacked documentation of such.

G-211

- Comp testing not in an HR file for HHA no longer employed.

G-224

- HHA careplan lacked direction for HHA to apply topicals: hemorrhoid cream, Zeosorb to skin folds, Nystatin.

G-225

- Assignment & Duties of HHA: Notes lacked identification of reason for omission of the task. HHA care plan assigned shower twice weekly, Aide performed a complete bed bath.
- Elastic stockings, compression stockings- careplan for HHA to apply but it was not on the 485.

G-229

- Supervision not done every 14 days - exceeded 14.

G-230

- Supervision of Aides did not occur every 60 days, of in person supervision.

G-236

- Clinical Records: Agency policy stated all SN visit notes be completed in 72 hours of visit and all admission documents be completed in 5 days of admit: not all notes completed in timeframe specified by policy.
- Electronic signature 4 days after visit was done. HHA visit notes not clear the HHA applied topical oint as assigned, or on some notes which topical oint was applied. Audit trails and watching completion/lock dates. Wound meas were inverted (length, width) by accident.

G-250

- Plan of correction stated agency would perform monthly clinical record audits through March 2018 then return to quarterly audits, the agency did not include a representation of all services provided since recertification survey.

G-322

- M2250 items on poc without doc of talking with doctor. Nurse documented ht/wt obtained in home visit but actually obtained from doctor office. Record has to indicate physician approved of best practices to be on POC.

G-337

- All components not documented as completed. Supplement with combination of vitamins- udpate med when product pateint obtains doesn't have all those same components. DRR not done with Recert. Eye drops not on med profile.

G-339

- Update of comp. assessment did not occur within the 60 day period.
- Comp Assessment electronically signed as completed after regulatory timeframe.

G-340

- ROC assessment- electronically signed after 48 hours. DC summary sent beyond time frame.

G-410

- Information to patient: Failure to obtain informed consent from & provide a description of patient rights with patient representative present. Documentation lacking of discussion of patient rights, informed consent for treatment, etc.

G-414

- The patients were not provided any document with the Administrator's name, address, contact info.

G-520

- SOC assessment was not completed within 5 calendar days- it was electronically signed on day 6. Audit trail identified nurse documenting assessment info on day 9.

G-528

- Comprehensive assessment lacked a weight on client with COPD, CHF, AFIB and patient had edema LE, SOB. Patient had scratch and an abrasion and an "old sore" where a Gtube had been removed- no wound measurements or wound assessment.

G-536

- Agency failed to complete a drug regimen review, including all required components with each comprehensive assessment.
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- Failure to identify medication discrepencies X 2. Unable to complete accurate drug regime review.
- Failed to complete drug regimen review for 2 patients: failed to document side effects, interactions, ineffective medication therapy and dup. medication therapy; Found additional medications in home and these were not listed on 4 concurrent POCs; Patient #2 discharge assessment lacked drug regimen review documentation.
- Patient #2 discharge assessment lacked drug regimen review documentation.
- Review of all current medications: Incomplete drug regimen review with each comp. assessment, including the patient discharge.
- All required elements of DRR were not documented as completed with each OASIS.

G-546

- Agency failed to ensure accurate completion of all required components of the recertificaation comprehensive assessments between day 56-60. Assessments not being locked before new cert period begins.
- 5 pts found to have recert late completion, signed after start of new period, drug regime reviews not completed to code.
- Recert completed after day 60, drug regime review not completed until 5-13 days after new cert period began.
- Incomplete components of the recert comprehensive assessment and submitted POC 1-3 days after cert had expired x 3 cert periods; Patient #2 discharge assessment lacked drug regimen review documentation.

G-548

- Resumption of Care assessment performed within 48 hours or on physician ordered resumption date.
- Assessment was electronically signed past 48 hours.
- Agency failed to ensure accurate completion of all pertinent components of the resumption of care within 48 hours of the agency's knowledge of return home.

G-550

- No drug regime review completed at discharge.
- Agency did not complete discharge comp. assessment within 2 days of knowledge of need of discharge.
- The DC comprehensive assessment was not completed within 2 days of the agency's knowledge of the need for DC.

G-572

- Agency failed to follow POC and orders authorized by a licensed physician and/or notify physician of changes in visit frequency: policy incorrectly indicated VO may be accepted from a PA or ARNP under supervision of a qualified physician, the order must be cosigned by supervising physician. Orders not co-signed by licensed physician. Lack of documentation of physician notification of missed aide visit.
- Failed to complete ROC assessment or obtain an order from the physician to resume services in 1 out of 3 clients ROC assessment was dated 3 days after discharge deadline and completed 4 days later.
- Agency failed to notify the physician of changes in visit frequency on the POC.
- Mepilex wound dressing not on POC; missed visit notifications were not completed.

G-574

- DME not on POC: grab bars and incontinence products. Patient reported to surveyor they used Ibuprofen twice daily for the last two months, RN was not aware and did not list on POC. POC lacked identification of pateint's prognosis.
- Plan of Care, inaccurate completion and/or failed to contain current data in 6 out of 10 patients. Chart and POC lacked current orders.
- Missing DME: short bed rail, scale, CPAP. Nurse had noted it on intake but due to software it did not populate on the POC.
- Agency failed to ensure accurate completion of all ocmponents comprising the POC. Patients over the counter medication not listed on the POC. PRN medications did not have dosage of medication.
- Medication list not completed, missing documentation explanation for when to administer "as directed", PRN medication for frequency, and how much; Missing DME - numerous in one home; Lacked frequency/duration of planned HHA visits for entire cert period.
- POC not complete: missing durable medical supplies used by patient named as incontinence products, Life Alert bracelet, shower chair.
- Plan of Care: failure to update changes in medication.
- Medication list had stool softener and not the specific name of the med; inahler lacked dosage of the med/dosage of med in each puff; supplements didn't have dosage; dosages on med profile didn't match what was in the home; Extended Release not noted on medications; Tucks pads lacked dose, freq, route.
- Lift chair, grab bars, toilet riser, reacher not listed on POC, leg brace, over the bed trapeze, bed rail not listed on POC.

G-576

- Agency failed to update the POC with new physician orders.

G-580

- Only as ordered by a physician: clinical record lacked a physician order for application of compression wraps. Clinical record lacked evidence of physician order for wound treatment of an abrasion/open area. Order lacked the specific catheter size and bub inflation size.
- Missing DME: insulin supplies, shower bench, sharps container, grab bars, walker, medication planner, incontinence supplies, pill cutter, emergency response button, elevated toilet seat, lift chair, wrist blood pressure cuff, reacher, medication trays, CPAP, trapeze; Lidocaine gel: did not note where to apply and if there was a daily limit; wound Care Orders 3 times a week but no direction or explanation on how to complete the dressing change; Coban and tubigrip ordered for wound care - no orders; feeding orders: no specific orders on how to complete the enteral feeding. Feeding type dropped off second POC; SN ordered but no duration or frequency; Menthol Zinc Oxide topical affected area on buttock as needed. No specific instruction to the patient/caregiver on how often to apply or a daily limit for use; Menthol Zinc Oxide topical affected area on buttock as needed. No specific instruction to the patient/caregiver on how often to apply or a daily limit for use.
- Patient with SN and HHA was hospitalized. With ROC orders there was no order to continue HHA visits or no order to continue any wound care. Prior to hospitalization there were wound care orders to be performed by the aide and RN.
- Failed to obtain physician order, while nurse was instructing family to provide cares to a burn patient.
- Failed to obtain physician order, while nurse collected urine sample and transported this to lab.

G-592

- Missing DME - back brace; Plan of care not updated to reflect current orders, no discontinuation of old orders.

G-616

- No med list in the homes on home visits.

G-622

- Agency failed to provide agency patients with written contact information of the agnecy's clinical manager, including clinical managers name contact information.

G-700

- Failure to alert physician to changes that may suggest a need to alter POC, and/or coordinate care with other staff for safe and effective care of clients; No discontinue on old orders, medications not being used.

G-706

- HHA noted red areas and RN aware but no documentation of RN assessment. Patient with scab from eyeglasses that were Healing when nurse saw- failed to measure. Scab from a cast- no measurements.

G-710

- Provide services in POC: Agency policy states staff will measure wounds weekly and as needed. Wounds measured did not include depth. Weekly measurements not always completed. Order for 1 SN visit a week for assess and wt - lacked documentation of wt obtained.
- Did not notify physician of a missed visit and inability to provide services as ordered on the POC; SN ordered but no duration or frequency; Pt. with monthly catheter change - nurse flushing catheter without an order. Nurse replaced catheter with a different bulb size than ordered; Providing services as ordered by the physician and indicated in the plan of care. Nursing failed to do so in 6 of 10 patients.
- Did not measure wounds or describe assessment of wounds.

G-718

- Communication with physician: clinical record lacked evidence of physician notified of presence of abrasion which required treatment. Clinical record lacked evidence of physician notification of edema.
- Failure to communicate the patient status with physician and coordinate care provided by other disciplines; RN did not obtain order for resumption of HHA services and wound care orders. HHA was instructed to perform a different wound care than what had been ordered pre-hospitalization. The HHA care plan was not updated to match instructions given to HHA. The HHA documented completing the wrong wound care and did not apply the walking boot that was ordered. No documentation that the nurse identified that the aide documented completing wound care without an order. The RN documentated that she had reviewed the HHA documentation. The RN Failed to effectively communicate and coordinate the delivery of aide services to ensure aide staff provided services as ordered.
- Client was discharged, HHA made visit 3 days after discharge, no notification to HHA of discharge.
- No clear concise coordination with HHA to direct patient care in the home. HHA did not receive written POC to follow; Documented NA to current assessment orders required at every visit; Did not document on ordered assessments; plan of care lacked documentation to provided assessment orders to reflect when such assessments would be completed, and what would occur of visits where assessment was not completed.
- Failure to communicate patient status with physician and coordinate care between other disciplines. Found that patient had run out of eye drops x 2 weeks ago and nurse did not communicate this with physician or reorder medication; Failure to obtain physician order, while nurse delayed changing PICC line dressing.

G-768

- RN signature not on the competency for a few skills.

G-772

- Competency evaluation of Home Health Aide:Agency failed to document assigned extra skills competency of aides, by an RN; Failure to communicate patient status between nurse and Home Health Aide regarding medication missing from home. Nurse did not coordinate with aide to reorder medication.
- Failure to maintain Home Health Aide competency documentaion of location of skills testing ~ whether in a lab setting using a pseudo pt. or home setting with an actual patient.

- Competencies above the CORE did not indicate if they were performed in the home or lab. Competency had to be very specific to which shampoo was performed (tub, shower).

G-774

- Agency failed to maintain home health aide documentation of at least 12 hours of in-service per year.

G-798

- No explicit direction in HHA POC ; No HHA documentation of communication with RN to report patients routine refusal of assistance, no change to POC to reflect services based on individual needs; Lack of documentation of parameters (weight changes) reported to physician in a timely manner per POC; Lacked documentation of frequent s/s heart failure to physician resulting in hospitalization; HHA omitted POC cares documenting NA to each instead of refusal, no SN documentation of reviewing POC with HHA on supervisory visits.
- Failure to provide individualized and specific POC for HHA, or supervise, and educate on issues noted during reviews.
- Failure to complete and update the Home Health Aide Care Plan, by the RN. Documented changes by the RN were not passed onto the the Aide's care plan.

G-800

- Agency failed to ensure home health aides provided care to agency patients only as ordered by the physician and /or directed by the skilled professional assigning the home health aide. Home health aide notes lacked reason for omission of task.
- Failure to ensure Home Health aides to provide services according to the aide care plan, as developed by an RN. Aide documentation lacked reasons why tasks were not completed.

G-808

- Agency failed to ensure a RN completed the hha supervision at least every 14 days.
- Onsite supervisory visit every 14 days: were not completed in this timeframe.

G-814

- Agency failed to ensure an RN completed home health upervision at least every 60 days while observing the home health aide present and providing direct patient care.
- Agency failed to ensure RN completed home health supervision at least every 60 days while observing the home health aide present providing cares.
- Failure to supervise non-skilled HHA services every 60 days; no coordination of patients care in an interdisciplinary manner; delay in getting physician orders for therapy, more than 10 days post visits. Therapy uploaded progress notes, agency did not print and fax to physician until 7-18 days after.
- Non-skilled supervision every 56-60 days. RN documented HHA was present, and observed HHA performing tasks. HHA documentation was for day earlier, and all tasks were performed at that time.
- Non-skilled direct observation every 60 days, when pt. receiving personal care assistance only: by RN to observe the aide, while aide is performing care.
- Supervision didn't occur with RN and HHA on site within 60 days- surveyor pulled time studies and times didn't overlap.

G-818

- Agency failed to ensure home health aide services are provided according to the home health aide care plan. The aide wrote N/A on note of an assigned task and had no reason as to why task was ommitted.
- Documentation of the supervision by the RN didn't contain all the elements; HHA visit note didn't identify all tasks assigned were completed.
- all elements in this tag have to be documented

G-856

- Agency failed to notify CMS and/or state survey agency of any changes in management.

G-1012

- Orders lacked physician signature.

G-1014

- Wound was cleansed with wound cleanser- no order. "Wound measurements the same" without specifying what the wound meas were. "Very hard to meas as one areas heals another opens up"- lacked wound assessment. Lack wound meas. PRN meds lacked frequency or amount or exact reason why.

G-1022

- Agency failed to complete and send a discharge summary to the physician or other health care professional responsible for providing care to the patient after the patients discharge. Patient records lacked having any discharge summary.
- Agency failed to complete and send a discharge summart to the physician or other health care professionals responsible for providing care to the patient after the patients discharge.
- Discharge/transer summary not sent to PCP within timeframe.
- Discharge documentation not completed. Blanks left open.

G-1024

- Agency failed to ensure all documentation included a signature and date and time of signature.
- Agency failed to ensure all documentation included a signature and /or date and time of signature.
- Audit trail of documentation showed completion prior to, and after visit to client; Electronic signature completed prior to HHA doing any cares; visit records lacked appropriate authentication of VS taken time.
- Therapy note had a typed name but no signature and date and time.

E-004

- Failure to have a formal written emergency preparedness plan.

E-017

- Policy on skin assessment was missing specific mention of wound assessment, and weekly measurements of length, width and depth; order to assess patient's depression and ability to cope. No documentation that this was being assessed; orders to assess patient's heart and lung sounds each visit - no documentation that this was being documented; Patient with unhealed surgical, depth only documented. No description of the wound bed to determine if there had been any reportable changes; medication set

up ordered. No documentation it was performed during the visit.ges to the wound; blood sugars outside parameters not reported to physician; patient with wound had no wound description on several visits. Nurse commented that wound was half the size of last week but there wren no measurements documented for the past visit; order to assess skin and perform wound care as needed. Patient had stage 2 ulcer to the coccyx. No complete assessment of that wound with measurements; Pulse oximetry monitoring order, No reading was taken during the visit; Patient was not provided with a written copy of the patient's individualized emergency plan; there was no documentation that the individualized emergency plan was ever developed.

- Agency did not have copy of the Patient Specific Emergency Plan.
- Patient specific emergency plans not done with comprehensive assessments.

E-019

- No emergency preparedness plan for homebound clients in need of evacuation assistance.

E-021

- No emergency preparedness plan for informing local and state officials of any missing on-duty staff or patients they were unable to contact.

E-024

- No EP plan to address the process and tole of volunteers in an emergent situation.

E-036

- No training plan developed for EP plan and related policies.

E-037

- EP Training Program -failed to ensure training for all existing and contracted staff.
- Training was not provided to contracted therapy staff.
- EP Training Program -failed to ensure training for all existing and contracted staff.
- No documentation of training/preparedness of staff, and contracted staff for EP plan, No demonstration of staff knowledge of emergency procedures.
- Contracted staff lacked evidence of training by Agency- they had been trained by their employer.
- Lacked proof of training contracted staff.
- No training of contract staff.
- Failed to provide training for contracted therapy staff.