Iowa Center for Home Care
HHA Survey Review G-Tags
2nd Quarter 2019

Total # of reports: 21
Recertification surveys: 9 (0 deficiency free)
Complaint: 5 (2 deficiency free)
Extended: 2 (0 deficiency free)
Revisits: 5 (4 deficiency free)
Inability to competize = 4
Validation survey = 0

Old CMS description of G-tags

New G tags

G414

- Home Health Administrator contact information not included in admission packet for multiple patients. Findings state Clinical Manager instead of Administrator, tag is specific to Administrator.

G418

- Failed to receive signature that patient or legal rep received the patient rights. Agency failed to provide a signed copy of the consent form to provide proof of receipt of the forms.

G434

- Failure to ensure agency staff informed patient or patients' representative of changes in care and ensure patient/representative consented to those changes. Lack of documentation to support communication to patient and representative on HHA schedule changes. Agency also failed to document complaints from patient and representative in complaint log.

G440

- Payment from Federally Funded programs: consent of patient acknowledgment of possible payments that may be their responsibility and informing them of change of payment status.
- Failure to ensure agency staff advised the patient on the extent to which payment for agency services may be expected and charges for services that may not be covered from Medicare, Medicaid, or any other federally funded or federal aid program known to the agency and charges the individual may have to pay before the agency initiated care. Clinical record lacked

documentation agency staff completed a new client financial data sheet prior to the patient starting PT services.

G442

- Written notice for non-covered care: admission consent was not available to prove that the client received the forms stating what their services would be ordered/performed.

G452

- Failure to have written policy/procedure for transfer of patient. Agency did not notify the patient of the agency's transfer policy.

G482

- Failure to conduct and document the investigation of a complaint made by a patient.

G484

- Agency failed to ensure the documentation of the resolution of a complaint made by a patient related to missing personal items.
- Failure to ensure documentation of complaints and resolution of a complaint made by agency patient.
- *Failure to document and maintain evidence of a complaint and the resolution of complaints, allowing the problem to persist without being addressed on multiple occasions. Patient reported concerns with the agency being unable to provide aide staff as scheduled for a period of several months. Additionally, staff didn't return calls regarding rescheduling. The patient's complaints weren't documented, and resolution of the complaints were not in the agency's complaint log. *(Stacked tag with G486 * below)*

G486

- Agency failed to have a written policy and procedure in place to investigate timeframe, investigation documentation, outcomes and actions.
- Failure to ensure staff acts to resolve complaints. Lack of documentation of agency's action to resolve patient complaint, including investigating or trying to resolve the complaint, in order to prevent any further violation of patient rights.
- *Failure of agency staff to act to resolve complaints placed patients at risk for not having identified complaints resolved in a satisfactory and timely manner and the potential for repeated offenses to occur. *(Stacked tag with G486 * above)*

G514

- Failure to provide initial assessment within 48-hrs of receipt of referral, within 48-hrs of agency's knowledge of patient's return to home from an inpatient facility or on physician ordered start of care date.
- Agency failed to provide an initial assessment visit in 48-hrs. Clinical record lacked documentation of a specific physician ordered start of care date.

G520

- Failed to ensure accurate completion of pertinent components of start of care comprehensive assessment within required timeframe. SOC OASIS not locked by day five.

G528

- Failed to include individualized assessment relating to patient's current health status when completing comprehensive assessment. Wound care orders did not have measurements at every visit as policy stated. Client checked blood sugars daily and recorded on paper, the assessment lacked documentation of any blood sugars.
- Health, psychosocial, functional, cognition: did not include wound assessment in the comprehensive assessment in patients.
- Failure to include individualized assessment relating to the patient's current health status when completing Comprehensive Assessment. D/C orders included wound care, and clinician failed to complete a thorough assessment of client's wound.
- Failed to ensure accurate/thorough completion of all pertinent components of comprehensive assessments. Visit documentation lacked wound care measurements.

G536

- Agency failed to accurately identify all medications taken by the patient with each comprehensive assessment/drug regimen review and/or failed to maintain an accurate list of medications, including times of administration.
- Review of current medications: Failed to identify medication discrepancies with the comprehensive assessment for clients. Nurse was in home to set up medications weekly but failed to identify discrepancy between the medication bottle and medication profile.
- Agency failed to accurately identify all medications taken by the patient with each comprehensive assessment/drug regimen review and/or failed to maintain an accurate list of medications, including times of administration. SOC lacked documentation of duplicate drug therapy, significant side effects and noncompliance with drug therapy.

G546

- Failed to ensure timely completion of recertification comprehensive assessment between day 56-60.

G548

- Failed to ensure accurate completion of all pertinent components of the resumption of care comprehensive assessment within 48-hrs of the agency's knowledge of return home.
- Failure to accurately and thoroughly complete resumption of care comprehensive assessments in a timely manner increased the potential that patients might not receive services in a manner to meet individualized patient needs.
- Resumption of care done but drug regimen review not completed by required five days; multiple occurrences.
- Failure to ensure timely completion of all pertinent components of resumption of care comprehensive assessment within 48-hrs of agency knowledge of the patients return to home from an inpatient facility.

G550

- Failure to accurately and thoroughly complete discharge comprehensive assessments in a timely manner increased the potential that patients might not receive services in a manner to meet individualized patient needs.

G570

- Failure to follow physician order for PT-moved date without information to physician; Failed to provide in writing, visit schedule to patients. Complaint logs show complaints by patients of lack of personal cares being provided. Medication list not updated and not given to patient. Nurse upon visit with surveyor found patient trying to clean herself up from a BM and nurse gave patient names of private duty caregivers.
- Discharge summaries not completed by agency.
- Failed to ensure agency skilled staff completed individualized POC that contained accurate information, failed to ensure agency skilled staff recorded all verbal orders in working plan, failed to provide medications, treatments and services only as ordered by a physician and failed to document physician verbal orders by authorized personnel in the clinical record.
- Failed to meet agency identified personal care needs of patient in the patient's home. Also noted in this tag were G 572 and G 574, stating the cumulative and egregious effects of these systematic practices resulted in the failure to ensure the organizational framework of agency promoted and supported the coordination of safe and effective delivery of care. Patient's clinical record lacked documentation of HH aide visits to assist with bathing and personal care. Patient's record lacked physician's interim order discontinuing HH aide services. Record lacked communication notes with the physician or reason for discontinuing. Another patient who was behind on insurance premium payments had services discontinued, but the medical record lacked documentation of how the patient would have his/her needs met during this time. Once insurance payments had been caught up, HH aide services were to be resumed, but the patient did not begin receiving services again for a week. A third patient called the HHA and requested to have an aide come out to change his/her catheter. Note didn't explain why the patient wanted the cath changed. Nurse told the patient he/she would not come out on an early visit to change the catheter. Instead the nurse gave patient instructions on the phone on how to change it him/herself.
- Services were not being completed in patient's home. Agency said because of behaviors they did med set-up and assessment in the HH agency office but billed under HH benefit.

G572

- Failure to follow POC and notify physician of need to alter POC. Agency didn't notify physician of change in visit frequency. This failure caused a resident to miss visits. Several clinical records lacked documentation of aide visits and reasons for missed visits.
- Failure to notify physician of changes in visit frequency ordered on the Plan of Care (missed visits). Clinical record lacked notification of missed visits to the physician.
- Agency failed to notify doctor of change in visit frequency and missed visits.
- Missed Therapy evaluation per Dr. orders. Physician not notified for several days after variation OT did not visit post 2-months after order given to evaluation ADLs. Did not provide personal cares as ordered and written. Missed baths/showers weekly. No documentation on why missed. Nurse-acting as an aide trimmed patient toenails and removed a callous from foot. Not on care plan. Physician called and complained. Visit schedule not in home and upon interview patient stated that schedule is only given to her verbally.
- Failure to follow POC established by a physician for multiple patients, placing them at risk of not receiving safe, individualized care to meet healthcare needs. Patient's clinical record lacked documentation of HH aide visits to assist with bathing/personal care. Electronic records didn't properly reflect actual HH schedule and visits; several visits were missed with no documentation of why. The clinical record for another resident lacked identification of the tasks completed or refused at a home visit.

- Fail to follow POC established and periodically reviewed or notify the physician of need to vary from physician ordered plan. Following wound care and dressing change orders, as ordered by the physician, including lack of wound measurements, description, etc.

G574

- Agency failed to ensure accurate completion of the POC; did not include all equipment/medications. Did not identify advanced directives patient had in place. Did not identify patient had a ramp with handrails, safety hand bar, handheld reacher, incontinent products, Lifeline, toilet riser, safety bars. Did not list all medications.
- Failed to ensure accurate completion of all components comprising the POC, including all supplies/equipment used by patient. POC lacked handheld shower special cushion in recliner for pressure relief, transfer belt, incontinent pads' lacked risk for rehospitalizations.
- Failed to ensure accurate completion of all components comprising POC, including all supplies/equipment used by patient. POC lacked handheld reacher, pacemaker test kit, quad cane, straight cane, TENS unit, Bipap machine. POC lacked any description of the patient's risk for potential emergency room and hospital re-admission.
- Failed to ensure accurate completion of all components required in the POC and/or failed to ensure it contained current information for multiple patients - missing medical equipment (glucometer, Lifeline, handheld reachers, urinals, and oxygen and supplies). Medication missing dosage/concentration.
- POC is to provide a list of DME- client had incontinent briefs list on visit but not on POC. Ramps and lift chair not identified on POC, failed to identify handheld shower.
- Missing risk factors/interventions to address underlying risk factors and info relating to advanced directive on POC (lacked DME). Medications on med list not found in home. Patient taking medications differently than prescribed on bottles and listed on POC. Frequency of medication not listed on POC; Patient had IPOST document stating wishes, but wishes were not on POC. No advance directive noted in patient POC or chart.
- Failure to ensure accurate completion of all components comprising the POC and/or failed to ensure POC contained current accurate information. Updating POC to accurately reflect how often RN was scheduled to set up medications.
- Failure to update Plan of Care with all new orders during the cert period. POC stated client had dentures, but client was observed by surveyor and didn't have dentures in, and clinician verified that they didn't have the means to receive dentures.
- Failure to maintain complete and accurate POC with current orders placed patients at risk to not receive services, medications and/or treatments according to assessed need and physician's orders. One patient's POC failed to indicate need for oxygen that included a filter flow and method administration as a current medication. Another patient's POC lacked identification of multiple medical equipment and supplies. Lack of documentation of patient's risk for ER visits and hospital readmission and any interventions or underlying risk factors. POC didn't identify advanced directives or code status. Also failed to update resuscitation wishes of patient when they changed.
- Failure to ensure accurate completion of components comprising POC; failed to ensure the POC contained current information. DME observed at home visit that was not on POC.

G576

- Failure to update the POC with interim orders on clients: missing order for frequency and duration of visits for OT.
- Working POC: Interim orders were not being entered as they were received throughout the cert period and they were not being entered as stated in the company's policy.

- Agency failed to update the POC with all new physician's orders.
- Agency failed to update the POC with all new physician's orders.
- Failure to maintain an accurate working POC and update the POC for several patients.
- Plan of care not updated to include updated physician orders (one working document). Plan of Care not updated upon resumption of Care or with medication changes as well.
- Failure to ensure all orders, including verbal orders, documented in plan of care. Lack of PT orders in the plan of care.
- Failure to update POC with all new orders for multiple patients with interim physician non-therapy treatment orders.

G580

- Nurse did not set up client's medications every 7-10 days as ordered. Twice weekly weights were not completed. Client had OT evaluation ordered but no subsequent OT orders. OT provided services without a signed order.
- Agency failed to administer medications and treatments only as ordered by the physician. The medication listed on the plan of care is not the dose in home and set up in the pill planner. Nurse inserted a Foley catheter that was the wrong size. Client had an order for three social worker visits and only one visit noted in the chart.
- Only as ordered by a physician: POC had order for weekly wound measurements but several visits were missing documentation. Second client had weekly weights to be done. There were weights missing from a some of visits.

G584

- Agency failed to assure nurses taking verbal orders from a physician documented the orders in the clinical record (signed, dated and timed) sending the orders to the physician for authentication including signature and date of signature.

G590

- Failure to promptly alert relevant physicians of changes in patient's condition/needs that suggest outcomes are not being met and/or that the plan of care should be altered. Lack of documentation to physician of patient's missed dosages of coumadin. Medical record also lacked documented communication of what LPN reported to RN Case Manager.
- Agency professional staff failed to promptly report changes in patients' condition. Agency staff did not report vitals that were outside of parameters.

G608

- Failure to ensure staff coordinated delivery of care to meet patient's needs. Failed to follow their policy and coordinate delivery of care between aides, nurses, and HH aide scheduler.
- Failure to ensure patient care delivery was coordinated in a way to meet patient individualized needs. Lack of documentation of specific time of administration of coumadin.

G610

- Failed to provide appropriate instructions on training. Client had an order for 3L/O2 and had oxygen set at 2L and was SOB and nurse did not recognize O2 was not set properly.

G614

- Visit schedule not in home and upon interview patient stated that he/she was never given a written schedule, visit information was always communicated to her verbally.

- Failure to ensure the patient and/or representative received a written visit schedule which included frequency of visits by agency personnel.

G616
- No medication list in the home given by agency. Upon interview, family and patient said they had never received any medication list from agency.
- Medication list did not give dosage list times of med administration

G622
- Failure to provide patients with written contact information for the agency's clinical manager's name and contact information (phone or email).
- Failure to provide patients with the clinical manager's name and contact information to a patient with a reported concern with agency services.

G682
- Staff did not follow infection control procedures for patients; continued to touch supplies without changing gloves and re-sanitizing hands. Cleansed a patient's wound with an alcohol swab after removing her glove (and not re-gloving). Measured wound with plastic measuring tool and returned to supply drawer without cleaning off the tool.

G706
- Ongoing interdisciplinary assessment of patient: skilled nursing and therapy providing services with no documentation of coordination of care in multiple patients. Failed to assess wounds. One patient had two separate plans of care for SN and PT. Failure to document ongoing care conferences with SN and Therapies. Patient had change in visit frequency orders for one discipline and it was not communicated to the other discipline. Agency stated there was telephone communication back/forth but did not document calls.

G710
- Med order was for 40 mg capsule (to treat acid reflux) that was delayed release. Upon med set up observation Nurse set up 2- 20 mg tablets twice daily to be taken 1 tab 2 x a day.
- Failed to ensure skilled professionals provide care as ordered by physician in POC; Clinician failed to document blood sugar readings/ blood oxygen levels as ordered by the POC

G718
- Communication with physicians: Failed to report changes and coordinate care with other staff and the physician regarding OT services.

G750
- HH agency failed to determine satisfactory competency with extra skills as an extension of nursing prior to assigning an aide to a patient.

G768
- RN didn't perform direct observation of HHA performance of required basic skills. Rehired aide previously employed for four years. Did not repeat competency testing for basic skills.
- Agency failed to ensure a RN or other appropriate skilled professional in consultation with a RN as appropriate performed direct observation of HHA performance of all extra HHA skills on HH patient; failed to evaluate written examination results to determine satisfactory competency prior to allowing the HHA to provide care independently.

- Aides did not receive competency training/evaluation on additional skills needed by patient.
- Failure to complete all basic skills competency for home health aides performed by RN; Lack of competency for sponge bath, tub bath, and shampoo in tub and bed.
- Failure to ensure RN performed direct observation of HHA performance of all required basic skills on a HH patient. Staff personnel file lacked documentation of all basic skills.
- Fail to ensure an RN performed direct observation of HHA performance of all required basic skills on a HH patient. Staff personnel file lacked documentation of all basic skills.
- RN did not perform direct observation of HHA performance of all required basic skills for one newly hired HHA. HHA wasn't directly observed performing partial bath, shampoo at sink, shampoo in bed and complete bed bath. Staff Reviewed these verbally with RN while client was receiving a shower.
- Fail to ensure RN or other appropriate skilled professional in consultation with RN as appropriate performed direct observation of HHA performance of all required basic HH skills on HH patient to determine satisfactory competency prior to allowing the HHA to provide care independently.

G798

- Failure to ensure the RN updated written patient care instructions for home health aide.
- HH aide assignments and duties: written instructions were not updated for HH aides for several patients. HH aide was directed to "check pressure areas" every visit. Directions lacked guidelines for what the aide was looking for or parameters for reporting issues to the RN. HH aides unable to assess and determine patient's needs or condition changes. The care plan was not specific, individualized and within the scope of practice of a HH aide.

G800

- Fail to ensure HH aides provided services according to HH aide written assignment. Aide assignment had the aide checking B/P, and there was no documentation the aide did it.
- HH aides failed to provide cares only as ordered by physician and/or as directed by skilled professional in several patients. Aide was assigned foot soaks, nail care, weigh patient every visit, check pressure areas every visit (extension of nursing services)- no documentation of physician orders for these tasks. Aide was removing and replacing Mepilex dressing when soiled - was not assigned by the nurse or approved by the physician.

G808

- Agency failed to complete home health aide supervision at least once every 14 days.
- Failure to ensure RN completed home health aide supervision at least every 14 days.
- Failure to supervise HHA services at least every 14 days increased the risk that patients received unsatisfactory or inappropriate care from HH services.

G814

- Failure to provide supervisory visits on non-skilled patient every 60 days.
- Failed to ensure registered nurse completed home health aide supervision at least every 60 days while observing each home health aide present and providing direct patient care.

G818

- Agency failed to ensure HH aides furnished care following the RN's assigned tasks and documented the tasks completed. RN did not perform elements of aide supervision.
- Multiple patients did not have all the required supervisory elements verified.

- Clinical Record of patient failed to document all required components of each aide supervisory visit.
- Failure to ensure the supervision of home health aides by RN's maintained documentation of a review of all required supervisory elements.
- Fail to ensure HH services were provided according to HH aide care plan as part of supervision. HH aide supervision lacked documentation of an open communication process, competency with assigned task, complying with infection control policies and procedures, reported changes in the patient's condition and honoring patient's rights.
- Failed to ensure home health aide supervision was completed with all required components.
- Patient with SN and HH Aide services lacked documentation of supervisory elements: communicating with patient and nursing staff, demonstrating competency for all assigned tasks, complying with infection prevention and control policies, reporting changes in the patient's condition and honoring patient rights for several patients.

G848

- Storing and pre-filling medications from agency office for patients. Meds stored in locked boxes with one universal code for all.
- Hired staff prior to background check being completed, then there was criminal background, but nothing noted in personnel file of follow up or clarifications. Failure to complete mandatory background checks according to State of Iowa requirements

G954

- Failed to have authorization in writing which identified a qualified designee appointed by the governing body to assume administrator's role if the agency administrator is not available.

G1012

- Failure to ensure clinical record included the patient's current physician orders. Clinician not updating plan of care with any orders given at time of discharge

G1014

- Failure to ensure the patient's clinical record included accurate documentation of interventions. Visit notes lacked wound measurements.

G017

- Agency failed to ensure the clinical record included a copy of an individualized emergency plan developed as part of the comprehensive assessment.
- Failure to ensure each patient or caregiver received a copy of the individualized emergency plan. Failure to ensure each patient had an emergency preparedness plan included as part of the comprehensive assessment for several patients.
- Individual plans for patients during a man-made or natural disaster must be included as part of the comprehensive assessment; did not maintain copies of individualized emergency plans as part of the assessment and did not ensure the patient has knowledge of their plans. No copy of plan in patient's home.
- Emergency Plan not in patient's home for all patient's surveyed.
- Failure to ensure the clinical record included a copy of an individualized emergency plan to keep in home. Surveyor at home visit asked client where their copy of Emergency Plan was yet it could not be found, and the medical record failed to have copy of the emergency plan.

G1022

- Agency failed to ensure a transfer summary was sent in a timely manner to the facility assuming the patient's care, and a discharge summary sent in a timely manner.

G1024

- Signature must be legible, clear, complete, authenticated, dated and timed.
- Authentication- Therapy notes have type written name but no signature of therapist. Agency was contracting therapies. Therapist would send not in email form to agency who would then type it on agency document and type therapist name, but therapist never reviewed or signed note in chart.
- Failure to maintain appropriately authenticated record clinical documentation. Several notes, physical therapy, speech therapy, and occupational therapy records lacked signatures and date or time of signatures.
- Agency failed to complete a written policy or procedure to outline the use of emergency staffing strategies which included state and federally designated health care professional.

E007

- Agency failed to ensure the integrated health emergency preparedness plan addressed the agency's home health population. Agency's plan only addressed people in the general public, not the agency's home health population.

E013

- Fail to ensure the agency has documented emergency preparedness policies/procedures.

E017

- Nurse did not complete and review with the patient an individualized emergency plan as part of the comprehensive assessment for several patients. Did not review and determine if patient had any changes with the comprehensive assessment.
- Failure to ensure emergency preparedness plan is documented/reviewed at each comprehensive assessment.
- Fail to ensure individualized emergency plan was developed as part of comprehensive assessment.

E019

- Homebound HHA /Hospice Agency failed to develop or have a plan to inform State and local officials of clients that are homebound. Agency failed to ensure the development of a procedure to inform state and local officials of homebound patients in need of evacuation due to an emergency situation.
- Failure to document in emergency preparedness plan to inform state and local emergency officials about homebound patients in need of evacuation due to an emergency situation.
- Failed to ensure the development of a procedure to inform state and local officials of homebound patients in need of evacuation due to an emergency situation.

E021

- Failure to have policy/procedures in place to inform state/local officials of on-duty staff/ patients that are unable to contact in event of an emergency placed agency patients at risk.
- Agency failed to have a policy and procedure to notify state and local officials of any on-duty staff or patients the agency was unable to contact.

E037

- Failure to ensure training in emergency preparedness to all existing staff, including those under contract, consistent with their expected roles. Training was not documented for most employees. Agency didn't assure initial training for their emergency preparedness/disaster plan and participation in training exercises to ensure employees' understanding of the plan.
- Agency failed to ensure training in emergency preparedness to all existing staff consistent with their expected roles for directly hired staff.

*Note: *Multiple emergency preparedness tags were cited to one agency due to lack of the agency having a plan in place that incorporates home health clients. Their plan only addressed the general public.*