Compliance Tips from IHCA's Home Health Survey Results Committee

March 2015

Breakdown of Survey Type:
4 Recertifications
4 Extended
6 Complaints
1 Re-visit

Number of Deficiencies:
103

Number of Agencies with Condition Level Deficiencies Resulting in an Inability for Agency and its RNs Prohibited from Providing Competency Training of Aides
4

<u>Top 5 Most Frequently Cited Tags (listed below)</u>

1. G Tag 159

- Agency failed to ensure accurate completion of all components comprising plan of care and failed to ensure the plan of care contained current information for 9 of 10 sampled patients (i.e. DME, medications, medical supplies)

- Incorrect documentation of DME in home.

- Agency failed to complete components of plan of care. Plan of care also lacked a discharge plan. Lastly, medication order that was PRN-lacked an identified frequency.

- Agency failed to ensure accurate completion of plan of care. Box 23 – verbal order for start of care must be updated with new date at recert.

- Agency failed to ensure accurate completion of all components comprising the plan of care and failed to ensure the plan of care contained current information for patients. (i.e. plans lacked identification of a goal related to hypertensions for a patient with a primary diagnosis of hypertension. MD order for diphenhydramine to be taken prn, but the orders and plan lacked identification of the frequency to take the medication daily. Plan of care directed skilled nurse to perform wound care, however, the plans lacked any specific directions or process for how the nurse should care for the wounds)

- Agency failed to ensure accurate completion of all components comprising the plan of care and failed to ensure the plan of care contained current information for patients (i.e. Plan of care for patient identified diagnoses of hip pain, atrial fibrillation, hyper tension and diabetes. The plan of care included orders for skilled nursing for physical

assessment, however, no specific components of a physical assessment were identified in order to determine what part of a physical assessment the nurse was to complete).

2. G Tag 158

- Failure to obtain physician order for PRN visit or documented reason. No physician contact made for blood sugar results beyond parameters. Again same patient for blood pressure.

- HHA failed to obtain orders from MD, DO or doctor of podiatry. A nurse practitioner was signed orders. Did not follow doctor orders for doing skilled nursing visit and did not notify doctor of missed visits. Order for labs draw which were also not completed.

- Agency failed to include planned frequency with planned interventions for social work and/or physician approved reason for PRN social work visits.

- Failed to ensure provision of services occurred in accordance with physician orders (i.e. MD orders to assess patient's wounds once weekly for 8 weeks. Nurse failed to measure all wounds during each weekly visit. MD orders directed skilled nurse to assess the patient's vitals each visit and the agency lacked documentation indicating the nurse assessed vital signs each visit. RN failed to remove the old date box from Box 23 and replace the old date with the date of the physician contact for the continuation of care for each new certification period).

- Failed to ensure provision of services occurred in accordance with physician orders (i.e. Orders for skilled nurse three times a week, but the clinical review lacked evidence of agency notification to the MD of the variance in the ordered service frequency. Box 23 – lacked evidence the agency obtained a verbal order from the MD to continue home health services before the start of the new 60 day cert period. Lacked documentation of the nurse's performance of the vaginal dilatation as ordered by the MD)

- Failed to ensure provision of services occurred in accordance with physician orders (i.e. plan of care dated 8/19/14-10/17/14 included orders for skilled nursing vitts 1 to 3 times a week. No skilled visit occurred during one week. Lacked documentation of evidence the agency notified the MD of the variation in the frequency ordered)

3. G Tag 236

- Agency failed to maintain pertinent clinical records with accurate and timely information according to professional standards (violated own policy to have all documentation incorporated within 14 days after care had been provided and proper way to document errors were not followed)

- Agency failed to follow policy to ensure staff maintain authenticated clinical records with complete and accurate data.

- Failed to follow policy for completion and accuracy in documenting in time required.

- Agency failed to 1) maintain clinical records of patient served at branch office and, 2) maintain patient clinical records with pertinent and accurate information which had been incorporated in a timely manner according to agency policy and failed to follow its policy when correcting errors in documentation.

- Agency failed to maintain pertinent clinical records with accurate and timely information according to professional standards (i.e. agency included 7 tasks under the 1052 task code. By including all 7 individual tasks under the same entry code, it was not possible to determine which tasks were actually completed during each visit).

4. G Tag 224

- Failed to provide individualized and specific written plan of care instructions for 4 of 5 necessary HHA service. (i.e. wound location, simple dosage changes, type of equipment being utilized).

- Agency failed to provide individualized and specific written patient care instructions to aides. (i.e. The home care aide flowsheet directed the aide to weight patient two times a week, but the care plan did not provide directions and did not specific when to notify the RN of a weight gain or loss. Directed aide to apply lotion to skin, but did not provide directions and did not specify the type of lotion or describe where to apply)

- Failed to provide specific and individualized written patient care instructions to HHA aides (i.e. care plan failed to provide directions to specify appropriate circumstances under which aides should give a shower or sponge bath, the type of lotion to use or to describe where to apply lotion, h how much assistance the patient required with ambulation and when to assist with dressing. Failed to include the type of wound care required for each wound on patient)

- Failed to ensure home health aide services occurred according to written plan.

5. G Tag 339

- Failed to complete re-certification assessments within the last 5 days of the 60 day certification period **x4**

Tags Resulting in Condition Level Deficiencies on Recertification Surveys

202 *Home Health Aide Services (42 CFR 484.36*)– HHA failed to complete performance evaluations for all home health aides at least every 12 months (G214), ensure aides completed a written test and demonstrated in the presence of an RN, a competent ability to to perform both

basic skills prior to being allowed to independently provide patient care and extra skills extending beyond the general training of a home health aide prior to providing the services to patients (G212), failed to ensure RN provided specific, individualized written instructions to home health aides for all tasks and services provided by aides (G224), failed to ensure the completion of home health aides supervision by RN at least every 14 days when patients received skilled services (229), and failed to ensure supervision by RN every 60 days (G230) **x3**

168 *Skilled Nursing Services (42 CFR 484.30)*- HHA failed to: 1) provide care in accordance with MD ordered plane of care (G170), 2) ensure the RN regularly and adequately assessed needs as an agency patients' conditions changed and 3) ensure the RN nurses coordinated information between case managers, LPNs, aides and other agency staff and patient physicians`

330 *Comprehensive Assessment of Patients (42 CFR 484.55)* – HHA failed to 1) ensure RN completed thorough timely and accurate start of care assessments within 5 days of admission to agency (G334), 2) maintain a policy directing staff when to complete a significant change in condition comprehensive assessment and failed to complete a significant change within 48 hours (G338), 3) ensure current, thorough assessments were completed when completing recertification comprehensive assessments (G339) and 4) ensure accurate completion of a discharge comprehensive assessment within 48 hours of the patients discharge from agency.

151- 153 *Group of Professional Personnel (42 CFR 484.16)* – HHA failed to 1) ensure the professional advisory council involved representatives of all disciplines, 2) to have advisory committee review agency policies at least annually, 3) to maintain documents summarizing advisory board routinely giving input and advising the agency