# Iowa Health Care Association
# HHA Survey Review G-Tags
# March 2016

The five most frequently cited tags from the 10 recertification surveys (0 deficiency free), 3 complaints (1 unsubstantiated), 1 revisit (both no deficiencies), recently reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 120 total deficiencies. **There were no condition level deficiencies and no partial extended or extended surveys. There were 2 Inability to Competize insufficiencies.**

**Total # of reports: 14**
**Total # of surveys deficiency free or unsubstantiated complaints: 1**
**Average # of deficiencies (all)**

- **All = 8.6**
- **Recertification =11.2**
- **Complaints=1.7**
- **Revisits=21**

**G-224** *(*42 CFR §484.36 Condition: Home health aide services) **Written instructions by the RN or therapist.**

1. No individualized plan of care provided for each patient.
2. Plan of care not individualized with patient information.
3. Agency failed to provide home health aide services according to individualized plan of care.
4. Home health aide assignment contained "PRN" for task, RN did not specify type of skin care, home health aide orders POS did not coincide with Home Health aide assignment sheet.
5. Agency failed to provide timely, individualized and specific written patient care plans written by an RN to home health aides, comprehensive assessment did not match written care plan, home health aide assignment not updated to have patient weighed at each visit.
6. Agency failed to provide timely, individualized and specific written patient care plans written by an RN to home health aides, care plan directed to assist with bathing and shaving and provide hygiene care but lacked specifics and detail.
7. RN failed to provide individualized and specific written instructions to home health aides, aide was performing tasks not on care plan.
8. Bath/bed/tub/shower all on one line lacking further specifics or detail on what type of assistance patient needed.
9. Plan of care failed to identify how home health aide was to administer medications, e.g, hand patient mediplanner, offer water, hold hand or head, encourage, etc.

**G-158** (42 CFR § 484.18 Condition: Acceptance of patients, plan of care & medical supervision) **Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine**.

1. Staff failed to notify physician of changes to plan of care for wound care, Foley catheter and medications, vital signs outside of physician-set parameters, missed visits and wound care not completed.
2. Plan of care did not include all tasks performed; not following plan of care, or following changes in physician's changes to plan of care, did not notify physician of visits missed.
3. Failed to follow plan of care, changes in plan of care not notified to staff, did not include frequency nor duration of visits.
4. Home health services provided before physician's order in place, SN did not apply 2 x 2 per physician's orders, nurse practitioner ordered lab tests SN drew per the VO but was not signed by the physician, Recert VO were not being updated in the L23, the L23 still had the SOC date, SN visits not provided according to ordered frequency and no missed visit notification to physician.
5. Nurse received verbal order from nurse practitioner but a written order was not signed by physician, documentation lacked evidence that a home health visit had occurred, nurse failed to record weight.
6. SN and home health aide visits performed as ordered, SN visit performed without physician's order.
7. Patient was out of state having surgery, lack notification to physician of missed visits, home health aide missed visit, lacked documentation of the reason.
8. Plan of care, failed to ensure physician directed all changes, PRN visits must include a specific reason for conducting a PRN visit, range of visits do not allow use of "zero," plans of care stated "up to" means from "zero" to specified amount.

**G-159** (42 CFR § 484.18(a) Condition: Acceptance of patients, plan of care & medical supervision) Plan **of care covers all pertinent diagnosis.**

1. Plan of care failed to include reason for PRN medication, plan of care goal did not match physician's orders.
2. Hourly extended care orders lacked specificity of number of visits per week, and for how many weeks, the orders read according the authorization which is written "up to the number of hours per week" for SN level of care.
3. Plan of care failed to address "nutritional requirements" section of care plan, DME such as blood glucometer and CPAP machine not listed in plan of care.
4. Agency did not follow time frame for emergency, no order to change, no reason for discharge, not included in plan of care, plan failed to be updated with new medications.
5. Plan of care not completed, did not notify physician of changes in plan of care, reasons for and goals for home care did not agree, failed to include DME on plan of care.
6. Failed to maintain a complete and accurate plan of care, plan must be updated each time something is changed, plan should include all DME, plan should include skilled nursing and home health aide visits.
7. Oxygen order did not include dose used with BiPap.
8. 485 did not include DME listing for wheelchair, cane, shower safety bar, handheld shaver, glucometer and ostomy supplies.
9. Oasis at recert said patient to dress lower body, home health aide assignment said assistance with dressing/undressing as needed.

10. Plan of care: no physician notification of DME, discharge plans, rehab potential and achievement of goals for each certification, reasons for any PRN medication, visits, community services, programs and other resources patient is receiving.

**G-236 (**§484.48 Condition: Clinical records) **Maintain in accordance with professional standards**

1. Agency failed to maintain records of patient for Galena, Illinois office.
2. PRN on home health aide assignments; when more than one option is listed on a home health aide assignment sheet, the registered nurse must specify which one the home health aide needs to do, the home health aide must specify which of the tasks was performed when more than one option is noted on a prepopulated form.
3. Home health aide assignment record listed "PRN," when what was needed was a set frequency, SN record signed electronically outside of time frame per agency policy, incorrect year noted on visit note.
4. Aide performing tasks not on care plan, some telephone notes did not include departure time, clinical record failed to correctly document start and end times in aides' notes.
5. Computer documentation lacked electronic signature and an internal clock with a date and time stamp, and no password protected security, clinical record lacked clarifying information or signatures of the authorizing physician.
6. Agency failed to maintain patient's clinical records, lacked clear, legible documentation, completed in a timely manner, failed to sign electronic documents being shared electronically, failed to follow agency policy on correcting errors, failed to complete documentation of a clinical visit with 48 hours, documents not attested and open to change, not correctly signed.

**G-337 (**§484.55 Condition: Comprehensive assessment of patients, standard: drug regimen review) **Comprehensive assessment must include review of all meds the patient is currently taking.**

1. Agency failed to maintain accurate list of medications.
2. Drug review not done correctly—no timely updating of medication review.
3. Medications for wound therapy is not documented.
4. All prescribed medications were not listed in plan of care and in DRR, medications listed in plan of care when patient had not taken them for a year.
5. Agency failed to complete all components of a drug regime review.
6. Agency failed to ensure drug regime reviews were completed.
7. Agency failed to complete all components of a drug regime review.