Iowa Center for Home Care
HHA Survey Review G-Tags
1st Quarter 2018

Survey type: 22 recertification surveys (3 deficiency free), 1 partial extended (1 deficiency free), 8 complaints (3 deficiency free), 3 revisits (0 deficiency free), 1 inability to competize and 1 validation survey (0 deficiency free) recently reviewed by the ICHC Survey Results Committee are listed below with narrative. There were 185 total deficiencies.

Total # of reports: 34
Total # of surveys deficiency free (revisits) or complaints unsubstantiated: 6

Average # of deficiencies

All = 5.44
Recertification = 8.60
Complaint/Extended = 1.00
Validation survey = 1.00
Complaints = 1.33
Inability to competize = 1.00
Revisits = 5.00

Survey Summary

G-Tags cited by Iowa Department of Inspections and Appeals

CMS description of G-tags

G-110

- Agency failed to provide the agency's policy related to advance directives to its patients. Admission packet lacked information regarding the agency's own policy related to advance directives

G-113

- Liability for Payment: agency did not tell clients in writing what their specific out of pocket expense would be for home health aide services for PP and VA clients
- No private pay agreement and failed to identify the cost of services and costs patient responsible to pay

G-114

- Failure to inform patient of out of pocket liability
- Agency failed to ensure patients received clear verbal and written identification of any potential out of pocket expenses the patient could expect to pay for services prior to the initiation of home care. Agency failed to clearly identify the funding source used for payment of the patient's services
- Agency failed to ensure patient's received clear verbal and written identification of any potential out of pocket expenses the patient could expect to pay for services prior to the initiation of home care

G-118

- Criminal background and dependent adult/child abuse checks not completed on contracted employees (1 out of 7) prior to employee beginning care
- Employee without criminal background or abuse checks within 30 days prior to hire

- Staff with a positive criminal history was allowed to work with agency patients before having that employee cleared by the Iowa Department of Human Services

G-121

- Cleaned nursing equipment with gloves and returned equipment to bag, then used cell phone to contact pharmacy, put a box containing patient pills in kitchen cabinet and checked contents of agency folder stored on top of patient refrigerator. Without cleaning hands, she entered her nursing bag and rearranged items inside bag. Therapist used hand sanitizer then assisted patient in LE exercises and without cleaning hands got insider her bag and removed TheraBand and assisted patient with more exercises
- Agency failed to make sure staff provided care in accordance with agency expectations and accepted infection control standards. Nurse touched unclean surfaces while setting up pills and did not resanitize her hands. Nurse did not sanitize hands before putting in clean nursing bag to retrieve nursing supplies
- Agency failed to ensure staff provided care in accordance with agency expectations and accepted infection control standards. Staff placed equipment back in their bag without sanitizing it
- Compliance with .accepted professional standards; based on home visit, clinical supervising RN denied that staff followed a written standardized procedure based on best practices such as sanitizing hands and changing gloves between multiple wounds on the same patient. Did not change gloves between multiple wounds on same client; did not sanitize forceps used for measuring depth of wound after using on another wound; risk of cross contamination
- Agency failed to ensure staff provided care in accordance with agency expectations and accepted infection control standards. Nurse did not change gloves when applying cream to feet

G-132

- Contracted out their services and did not believe they had to comply with the Medicare COPs

G-145

- 60-day summaries not sent to physician
- Not recertifying VA patients within 60 days because VA only pays for nurse to do a visit within 6 months (per agency) no 60-day summaries to physician

G-153

- No policy review evidence in meeting minutes with advisory board

G-156

- No written plan of care established by MD, DO or Podiatrist, initiated by RN and reviewed by physician q 60 days

G-158

- Did not notify physician of changes in visit frequency; no specifics on need for PRN visit
- Agency failed to ensure nursed provided care as ordered by the physician. RN did not do dressing change as ordered and did not include reason for omission
- Failed to follow POC and report to physician of changes in visit frequency-NO DOCUMENTATION
- Agency had recertification dates for all VA patients as every 7 months and not within 60 days

- Failed to follow written POC (as not completed as above)
- Agency failed to notify the physician of changes in the patient's condition that would require modifications to the POC. Agency did not obtain a resumption of care order when the client returned home from a hospital stay to continue services

G-159

- Agency failed to ensure accurate completion of the patients POC. Not all DME equipment listed on POC
- Agency failed to ensure accurate completion of all components comprising the POC. PRN medication did not provide frequency of the medication. Not all DME was listed on the POC. Discharge plan failed to identify under what specific conditions the agency planned to discharge the patient. PRN medications lacked route or dosage. POC failed to include an accurate list of the patient's current medication. Not all DME equipment in the home was listed on the POC
- Agency failed to ensure accurate completion of all components comprising the POC and/or failed to ensure the POC contained current, accurate information. Client had order to apply thin layer of antibiotic ointment but did not specify what type of antibiotic ointment it was, agency failed to ensure the POC contained complete medication orders. Discharge plan failed to identify under what circumstances the agency would discharge the patient from services
- Agency failed to ensure the accurate completion of all components comprising the POC and/or failed to ensure the POC contained current, accurate information. POC failed to specify under what circumstances the agency planned to discharge the patient. There were medications on the clients POC that they had not taken for a long time. POC did not identify all DME equipment
- Agency failed to ensure the accurate completion of all components comprising the POC. POC lacked a specific goal for home health aide services and what an acceptable level of pain would be for the patient. POC did not have all DME listed. POC failed to identify any nutritional requirements
- Agency failed to ensure accurate completion of all components of the POC and /or failed to ensure the POC contained current, accurate information. Client had order for PT to eval and treat the chart had no documentation that this was done. Client had order for Foley but no balloon size to keep Foley in place. POC did not have all DME listed on it
- Agency failed to ensure accurate completion of all components comprising the POC. POC did not have all DME equipment listed. POC lacked over the counter medication listed, POC did not include the patients rehab potential. POC lacked an order for oxygen
- Raised toilet seat was not listed and observed on home visit; observed additional equipment and supplies not on the assessment: incontinent briefs, pressure relieving cushions for patient recliner and w/c; handheld shower; bp machine; therapy band; toilet riser. Additionally, on home visit of another patient-crutches and cane were listed and not observed. Patient stated had not used crutches since 2001. No d/c plan
- No discharge plans; No documentation of supplies for catheter as used by patient for self cath. Medication dosages not listed; missing bed rail found in patient home upon home visit
- Plan of care lacked patient specific and individualized goal for nursing and aide services; No plan of d/c; PRN medications but had specific dosage and times
- Plan of Care: Based on clinical record review, home visit observation, agency policy, patient review, and staff interview…..failure to maintain complete and accurate POC with current orders…..patient kept pill bottles in locked "tackle box" and this was not listed as DME on POC.....Door alarms not identified as DME on POC....Discharge plan on POC

was stated as "None at this time due to need for....; failed to specify under what circumstance agency planned to discharge the patient....Cane and ramp were not identified on POC as DME.....Order for O2 was "every day inhalation; failed to specify amount and freq.....Order for A&D was "external every day as needed when wound opens"; failed to specify where it should be applied (right leg/buttock crease.....lift chair, hospital bed, shoe horn not listed on 485 as DME....Pro air inhaler order was for 2 puffs twice a day; patient reported using only as needed for years and that physician was aware.....Discharge plan was listed as "none unless the patient's condition changes; failed to explain what condition changes would necessitate a reason for discharge

- Plan of Care: Triamcinolone cream "external" twice daily did not specify a location or reason to apply…..POC did not include a discharge plan….no reacher on POC for DME…..POC did not identify the pts prognosis….POC did not identify DME of sock aide, Reacher, long handled shoehorn.....Hand held shower not on DME on POC....incontinent briefs, lifeline, grab bars, shower chair, walker not listed on DME/POC.....Mupirocin ointment ordered twice daily external but did not say where to apply...
- Insulin syringes….POC lacked functional limitations……POC lacked specific dx…..POC lacked specific reasons for discharge....POC lacked specific list of meds...
- Failed to notify physician of orders of weight gain; outside of glucose parameters; no specific discharge plan; medications not listed (glucose tabs, Tylenol, Oxycodone)
- Failed to complete POC with equipment needed, nutritional requirements, and safety measures; no goals or discharge plan
- Agency failed to ensure the accurate completion of all components comprising the POC and/or failed to ensure the POC contained current, accurate information. POC failed to list all DME supplies. Incorrect date on SOC date entered so as a result all other OASIS have an incorrect date. Discharge stated self-care but lacked under what circumstances the agency planned to D/C the patient. Medication order lacked frequency on PRN medication

G-165

- Agency failed to administer medications and treatments only as ordered by the physician. Nurse did not obtain an order prior to performing a treatment. Agency failed to follow the physician ordered POC and/or notify the physician of changes made to the POC. Clients buttock cream discontinued but home health aide continued to apply the cream
- Agency failed to administer treatments only as ordered by the physician. POC did not have all DME equipment listed. Nurse failed to obtain an order to change Cather prior to completing the task. Pts. Chart lacked order for G-Tube feedings
- Conformance with Physician Orders: Order was for 28 FR catheter with 5-10cc balloon; nurse unsuccessful @ insertion of 28 Fr so attempted with 20 FR 5 cc and inflated with 4 ml; RN contacted physician to report but no order for different size catheter.....Nurse inserted a 26 Fr catheter but no order from physician for that size catheter; order was "extra SNV to replace the SP catheter that was pulled out that morning".....
- Failed to administer medications as ordered
- Nurse set up medication for stool softener of which no order from physician. Nurse put on ace bandage on a painful left wrist without order for ace bandage
- Agency failed to administer medications and treatments only as ordered by the physician. Nurse set up wrong medication dose in pill planner

G-168

- No coordination of care with aides, therapy or patient physician

G-170

- Agency failed to ensure RN provided care as ordered by the physician. Nurse did not have full set of vitals on visit note. Nurse failed to document teaching at each visit as ordered on the POC
- Skilled Nursing Services: Order for Vit B12 500mcg and nurse filled planner with 100mcg; pharmacy delivered wrong dose, but nurse did not check the label
- Documented on nursing visit notes "nursing assessment differed"-had no plan of care
- No documentation for order vital signs; No logs of BS as ordered by physician to be faxed to office. Nurse visit where one item to address was set up medications, but no documentation of med set up by nurse
- Agency failed to provide individualized and specific written patient care instructions assigned by a RN or therapist, for patients receiving either skilled nursing and home health aide services, or for patients receiving therapy and home health aide services. The home health aide care plan included the assigned tasks of "assist with tub/shower, assist with personal care, assist with ambulation, apply lotion to legs. The assignment did not specify when the aide should perform each type of task and did not specify what personal care tasks the aide was being assigned to assist the patient with skilled nursing services; Agency failed to ensure nurses followed urinary catheter insertion as ordered by physician; did not use Lidocaine as ordered, patient experienced "quite a bit of discomfort" and blood-tinged urine upon insertion, later reported high bleeding and eventually went to ER.

G-172

- No documentation of wound measurements
- Agency failed to ensure RN's reassessed and documented the results of the reassessment in the patient's clinical record according to agency policy. Clinical record lacked documentation of wound measurements
- Agency failed to ensure the agency's nurses adequately reevaluated the pts. Status and response to care to provide appropriate individualized care. Wounds did not have all 3 measurements
- Agency failed to ensure the agency nurses adequately reevaluated the patient's status and response to care, to provide appropriate individualized care. Visit note lacked wound assessment or photograph
- Agency failed to ensure the agency's RN's reassessed and documented the results of reassessment in the patient's clinical record. Client had wound on sacrum, but record lacked assessment of this
- Wound measurement lacked depth of wound; no wound measurements at all
- Failure to re-evaluate-medication changes without evidence of orders; medications prescribed not in-patient home-physician not notified
- Agency failed to reassess wounds as directed by agency policy. Wound assessment lacked patient's coccyx or lower back/hips. Wound assessment lacked any measurements
- Agency failed to ensure accurate completion of all components of the POC and /or failed to ensure the POC contained current, accurate information. Client had order for PT to eval and treat the chart had no documentation that this was done. Client had order for Foley but no balloon size to keep Foley in place. POC did not have all DME listed on it

G-176

- Agency RN's failed to report to the physician, patient status changes requiring a need to alter the POC, and/or failed to coordinate patient care with other disciplines. Patient vital signs exceeded parameters set by policy and physician not notified
- Failure to communicate patient status with physician and coordinate care with other disciplines
- Agency failed to ensure that RN's coordinated between other services offered by the home health agency and with physicians. RN did not report a weight gain of over 3lbs to the physician. RN did not notify physician of blood sugar that was out of range, PT evaluations not being done in 72 hours according to policy
- Agency failed to ensure RN coordinated pt. care with the pts. Physician. Order was for RN to ask pt. weekly about blood sugar results and report concerns to the physician but there was no documentation in the chart that the nurse asked about blood sugars. Nurse did not notify doctor of weight gain over 3lbs
- Lack of reassessment of POC upon resumption or significant change to patient
- Duties of the RN: Failure to communicate the patient's Failure to communicate the patient's status with the physician and coordinate care provided by other disciplines…..next regular scheduled visit was to be a recert visit and note had been left for nurse seeing patient to set up 2 additional days of meds but nurse seeing client did not; client ran out of meds
- Lacking interventions for diabetic education and related diabetic foot care. Missing wound measurements; not updating aide care plan to add tasks
- Agency RN failed to report changes requiring a potential need to alter the POC to the physician. Nurse did not notify physician of patient's noncompliance with medication regimen

G-202

- PRN aide assignments lack of specificity; skin care failed to state what skin care entailed
- Agency failed to maintain adequate documentation of compliance with the regulation for home care aides

G-210

- HHA Training/Documentation: No documentation of where (lab on a pseudo patient or actual patient) aide received training for "extra skills" of simple dressing change…..Staff reported that competency testing had taken place with live patient at hospital; conducting basic and extra home health aide skills in a hospital is not similar to evaluating an aide's ability to perform the same skills competently in the patient's home with no assistance and sometimes with less equipment or supplies present or available
- Agency failed to document whether extra skills competencies were evaluated in a laboratory setting using a pseudo patient or in a home setting whole being performed on an actual patient
- Agency failed to ensure a RN documented the review of written basic home health aide competency exam and/or completed the competency evaluation for basic skills verbally with the aide
- No RN signature or date of evaluation for aide examination
- Agency RN failed to evaluate the results of the written basic home health aide competency exam and/or completed the competency evaluation for basic skills verbally with the aides. There was no RN signature on the written test

G-211

- Agency failed to ensure all home health aides successfully completed a competency evaluation program for all the basic skills competencies prior to providing car to patients

G-212

- Agency failed to ensure home health aides assigned to perform tasks requiring extra skills exceeding the level of basic home health skills had documented evidence of competency by a RN in the assigned task prior to independently performing on a patient
- Competency Evaluation and In-service training: agency failed to show that 5 of 6 sampled aides assigned to perform tasks requiring extra skills exceeding the level of basic home health skills for 3 sampled patients had completed a competency by a RN in the assigned task area prior to independently performing the task with a patient; extra tasks included: shaving, simple dressing change, suprapubic cath care including cleaning bag with baking soda and soap, application of a leg brace/prosthesis, application of a medicated ointment, use of Hoyer lift
- Competency Eval and In-service training: Agency failed to ensure that 4 of 7 sampled home health aides assigned to perform tasks requiring extra kills for 1 of 6 patients had documented evidence of competency by a RN in this task….no evidence of competency for aides on ordered wet to dry dressing, wound packing and application of CAM boot
- Agency failed to ensure home health aides assigned to perform tasks requiring extra skills exceeding the level of basic home health skills. Home health aide was assigned to shave a client but had not been checked off on the extra skill before performing it

G-214

- Performance review of home health aides not done within 12-month period
- Agency failed to ensure the completion of a performance review of each home health aide no less frequently than every 12 months
- Agency failed to ensure the completion of a performance review of each home health aide no less frequently than every 12 months
- Agency failed to ensure the completion of a performance review of each contracted home health aide no less frequently than every 12 months

G-218

- Competency Evaluation and In-service training: Agency failed to ensure a RN performed direct observation of home health aide performance of all required basic HHA skills on a patient or pseudo patient in order to determine satisfactory competency prior to allowing HH aide to provide care independently to agency patients for 1 or 2 sampled HH aides.... HH aide had not completed the competency for oral hygiene

G-224

- Agency failed to provide individualized and specific written pateintt care instructions from an RN to agency home health aides. The aide care plan instructions were to assist with a shower per the patient's request and to assist with transfer in and out of the shower. The instructions implied the patient had to request the shower rather than the RN directing the patient care
- Aide assignment missing cares that aide was performing; lack of specificity for aide care plan
- Agency failed to provide individualized and specific written patient care instructions assigned by the RN to agency home health aides. Home health aide care plan directed

the aide to assist with skin care and assist with personal care, but the care plan did not specify what that was

- Assignment and Duties of HH Aide: Agency failed to provide written patient care instructions directing the care by HH aides for 8 or 8 sampled patients….RN directions to the aide to complete tasks of skin and hair care but assignment lacked specific direction to the aide to explain what exactly to do for skin and hair care.....another laced direction as to what to do for skin care (aide applied lotion to back).....another lacked direction for what to do for skin and hair care.....this was on all 8 of 8 sampled patients
- Aide care plans were done so that it implied patient had to request cares instead of RN directing cares to be completed for patients
- Agency failed to provide individualized and specific written patient care instructions assigned by a RN to agency home health aides. Cannot have PRN on a home health aide care plan as the aide cannot assess if they are to do something
- Agency failed to provide individualized and specific written patient care instructions assigned by a RN to agency home health aides. The home health aides cannot assess a prn order on a care plan
- Agency failed to provide specific written instructions from a RN or other appropriate professional who is responsible for the supervision of the home health aide. The aide assignment failed to include instructions to the aide to apply lotion per physician orders
- Agency failed to ensure the agency staff maintained accurate and complete documentation in a timely manner. Skilled visit note lacked weight. Clinical record lacked documentation of when the patient was discharged from the hospital and how the agency became aware of the patient's hospital discharge. Skilled visit note lacked vital signs
- Agency failed to provide individualized and specific written patient care instructions from a registered nurse to agency home health aides. Aide care plan directed the aide to apply arthritis cream to shoulders PRN, this is beyond the scope of practice for a home health aide

G-225

- Agency failed to ensure all home health aides provided services only as ordered by the physician and according to the home health aide written assignment and document the tasks completed during home health aides visit. HHA applied elastic stockings to the patients left lower leg and it was not on the care plan to do
- Agency failed to ensure home health aide provided care according to the care plan. Care plan directed aide to apply lotion to legs weekly and care plan showed the aide applied it daily. Aide applied lidocaine lotion to the patient’s shoulder and it was not on the care plan for the aide to do
- No documentation to evidence tasks assigned by RN were completed (i.e.; blood sugars, medication reminders; weights; shaving
- Not documenting cares by aide-with no reasons given
- Agency failed to ensure home health aides provided services according to the home health aide written assignment. Aide assignment had extra skill of catheter care, apply TED hose, shave and weigh patient, aide noted did not document that the aide weighed the patient

G-229

- Failure to supervise aides at least every 14 days for skilled services
- Agency failed to complete home health aide supervision at least once every 14 days

G-230

- Supervision: Direct supervision for aide no less frequently than every 62 days for clients not receiving skilled care….SV notes all indicated that supervisor occurred when aide was not present in patient's home…..aide supervision occurred 16 to 25 days late
- RN lacked documentation of direct supervision of aide and cares RN observed
- Failure to supervise aides 60 days for non-skilled services
- Aide supervision not done within 60 days on non-skilled patients-up to 37 days late

G-236

- Agency failed to ensure the agency staff completed and incorporated accurate documentation into patient clinical records in a timely manner and/or corrected errors in documentation according to agency policy. Visit notes were not locked in timely manner according to agency policy
- Agency failed to ensure the agency staff completed and incorporated documentation into patient clinical records in a timely manner. Clients chart lacked documentation of the full evaluation completed by PT & OT. Nursing visit notes not locked in timeframe listed on agency policy
- Agency failed to maintain patient clinical records with pertinent, accurate, consistent and timely information according to professional standards. Patient #10 did not have telephony services appropriately set up so there was no record of the cares performed by the home health aide. Electronic visits were not signed in a timely manner
- Visit notes not turned in as according to agency policy timeline
- Agency failed to ensure the agency staff maintained accurate and complete documentation and incorporated documentation into patient clinical records in a timely manner. Staff were not locking visit notes within agency policy timeframes. Visit not lacked documentation of wound assessment. Client had order for nurse to set up medication but visit note lacked documentation that this had occurred. Clinical note lacked evidence of completion of a discharge summary
- Clinical Records: Complete and timely incorporation of documentation into the clinical records…….policy was for therapists to complete the documentation the same day of visit but turn in the visit note by the Monday following the visit. Then agency staff file the therapy notes within 7 days of receiving the note....POC started 9/23/17 and PT and OT ordered, clinical record review conducted 10/10/17 lacked documentation of any PT or OT evals or notes.....a skilled nurse visit note dated 7/28/17 included documentation of a visit time but no further documentation; nurse had handwritten documentation that she reported was entered but not sure what happened to it.....POC dated 8/1/17-9/29/17 included an order for one OT visit for eval/treat within 7 working days; clinical record lacked documentation of any OT visit, a physician's order to cancel the visit or a reason why the OT eval was not done; contracted therapy company says that pt refused and that they notified doctor and HH company but no documentation
- Not following policy on documentation correction policy-one line through error, initial, date and record time staff corrected. Not following policy when documentation is incorporated into the chart. Signatures not dated on documentation
- Clinical Records: Failure to maintain complete and timely incorporation of documentation into the clinical records….policy was stated as to complete documentation within 48 hours of visit unless visit was on a Friday or holiday in which case was to be completed on following day; aides were to submit documentation within a week of the visit by the following Monday.....OT note signed but lacked a date to show when the document was completed....PT note signed but PTsig not dated.....PT visit note had entry written over another entry with no single line or initials or date.....financial

form contained and entry written over another entry...agency says no policy for corrections....referral form entries were all in pencil.....OT eval occurred on 10/25 but not documented till 11/1.....on 11/6, no aide visits scanned into patient's record since 10/11.....POC order was for aide visits 4-5 times per week first 2 weeks but only 2 aide visits documented the first week.....

- Home health agency failed to maintain patient clinical records with pertinent, accurate, consistent and timely documentation electronically signed and/or incorporated into the clinical record according to agency policy. Original documentation had been covered up with white correction tape. Mistaken entries not corrected per policy. Visit notes not electronically signed within in allotted time frame of agency policy
- Lack of signature on documentation by nurse; lack of dates of signature on documentation by therapies, lack of wound measurements

G-250

- "Chart audits not completed by appropriate licensed professionals representing service being reviewed (OT; PT; RN, etc.)
- Chart audits not done by licensed providers of service delivered (OT; PT)

G-303

- Failure to notify physician of availability of d/c summary
- Clinical Records: the HHA must inform the physician of the availability of a DC summary; DC summary must be sent to the attending physician upon request and must include the patient's medical and health status at DC…..DC summary only identified the patient was camping and would not be returning prior to the end of the cert period but lacked written synopsis of the patient's course of treatment, including services provided
- Clinical Records: Agency failed to ensure that physician was aware of availability of DC summary…..agency reports that they send out a DC summary but do not maintain any documentation to show that this occurred

G-321

- Agency failed to transmit OASIS data within 30 days

G-322

- Agency failed to transmit accurate OASIS data items collected with each comprehensive assessment. Agency planned to place patient specific physician ordered vital signs and other clinical findings within a specific timeframe. The patients clinical record lacked documentation indicating the patient’s physician agreed to any patient specific parameters
- Agency failed to transmit accurate OASIS data with each comprehensive assessment. The agency planned to place patient specific physician ordered vital sign and other clinical findings parameters for reporting on the POC. This indicated the agency planned on participating in best practices, but the clinical record lacked documentation that the physician agreed with the specific parameters
- of encoded OASIS date: Agency failed to transmit accurate OASIS data …….OASIS reported that agency SOC included a pain assessment using standardized, validated pain assessment tool and considered "best practice" but no documentation in patient clinical record of assessment tool.....this was found in 3 charts
- Failed to transmit accurate OASIS data; taking credit for best practices agency not actually participating in

- Agency failed to transmit accurate OASIS assessments, nurses were not documenting if the physician approved best practices to be placed on the POC
- Agency failed to transmit accurate OASIS data for adult patients who required transmission of OASIS at specific time points. The agency indicated they planned to participate in best practices, but the clinical record lacked documentation indicating the patient's physician agreed to placing this on the POC

G-330

- Lack of timely start of care comp assessments; drug regimens not completed including OTC; not accurate ROC; comp assessment not completed within 48 hours

G-332

- Agency failed to provide and initial assessment visit within 48 hours of receipt of referral from the physician

G-334

- Agency failed to ensure accurate completion of all the pertinent components of the SOC assessment within the required timeframe. Assessment lacked wound measurements. Assessment lacked height and weight. SOC assessment not being locked with 5 days of start of care
- Agency failed to ensure accurate completion of all pertinent components of the start of care comprehensive assessment within the required timeframe
- Agency failed to ensure accurate completion of all pertinent components of the start of care assessment. Assessment of wound did not have depth
- Accurate and timely start of care; oasis M1100 indicated patient lived at home, but resided in an Assisted Living; large amount of inconsistencies between Oasis date questions and POC
- SOC comp assessment lacked height and weight with no reason why not reported
- Agency failed to ensure accurate completion of all pertinent components of the start of care comprehensive assessment within the required time frame. SOC assessments not locked within 5 days of visit. Assessments lacked wound measurements and temperature readings

G-337

- Agency failed to ensure a thorough drug regiment review was completed as part of the comprehensive assessment
- Agency failed to ensure RN staff completed a thorough drug regimen review as part of the comprehensive assessment. Medications in the home did not match the medication drug sheet
- Agency failed to include all prescription and over the counter medications taken by the patient when completing drug regimen review. The review of the patient's medication did not include ineffective medication therapy
- Agency failed to ensure a thorough drug regimen review was completed. Clinical record lacked order for face cream. Plan lacked order for BioFreeze. Staff failed to complete a drug regimen review of all the patients medications
- Failure to complete thorough and accurate drug regimen reviews for the comprehensive assessments; side effects; all meds including OTC, non-compliance of drug therapies; duplications of meds, ineffective drug therapy
- OTC meds not listed on drug regimen; PRN listed without dose, route, maximum amount to take in period of time

- DRR: Clinical record lacked physician orders for OTC med client reported taking such as Advil, Tylenol, Aleve, testorone booster, preservation
- DRR: Duplicate meds including BP, respiratory, and diabetes meds lacked documentation for assessment of the meds for duplicative medications…..recert lacked any of the components of the DRR……SOC lacked any component of DRR….ROC lacked any components of DRR....

G-339

- Agency failed to ensure accurate completion of all pertinent components of the recertification assessment between day 56 to 60. OASIS not locked by day 60. Comprehensive assessment did not include wound measurements
- Agency failed to ensure completion of all pertinent components of the recertification assessment between day 56 to 60. Recert assessment not locked within 5-day window, agency failed to ensure accurate completion of all pertinent components of the Resumption of care within 48 hours of their return home. Resumption of Care not locked with 48 hours
- Agency failed to ensure completion of all pertinent components of the recertification comprehensive assessments between day 56 to 60
- Agency failed to ensure accurate completion of all pertinent components of the recertification comprehensive assessment between day 56 to 60. Assessment visits locked after day 60
- Agency failed to ensure completion of all pertinent components of the recertification assessment between day 56 to 60. Recert assessment not locked within 5-day window. Visits not locked by day 60
- Update of the Comprehensive Assessment: Failure to accurately and thoroughly complete the recert comprehensive assess in a timely manner…..recert lacked pt height, weight or a reason why a ht and wt was not obtained…..orders for SN to include VS every visit; recert assess lacked patient's pulse.....POC dated 7/13/17 to 9/10/17 had recert assess dated 7/14/17 with lock date of completion of 7/18/17 (exceeding regulatory and agency requirements by 5 days)
- Agency failed to ensure accurate and timely completion of all pertinent components of the recertification comprehensive assessment between days 56 to 60. Recert lacked documentation of temperature
- Recertification comp assessment late; missing patient bp, pulse and weight; multiple late recert dates
- Recert assessment included wound cares but lacked measurements that included width, depth, length. Recertification assessment completed 7 days prior to cert period. Patient missing 17 Comp Reassessments since initial SOC assessment
- Agency was not recertifying VA patients at 60 days-but at 6-7 months due to only one nurse visit at 6 months

G-340

- Agency failed to ensure completion of all pertinent components of the resumption of care assessment within 48 hours of knowledge of return home from an inpatient stay
- Update of the Comprehensive Assessment: Failure to accurately and thoroughly complete the ROC comp assessments in a timely manner (within 48 hours of agency's knowledge of return home from input facility)….COMM note that client coming home 7/18/17, ROC visit made on 7/20/17 and locked as completed on 7/22/17 which exceeded the requirement by 1 day; the assessment lacked ht or wt or a reason why ht or wt not obtained

- Agency failed to ensure accurate completion of all components of the resumption of care assessment with 48 hours of the agency's knowledge of return home from an inpatient stay.
- Agency failed to ensure accurate completion of all pertinent components of a resumption of care assessment within 48 hours of the patients return home from an inpatient stay, or within 48 hours of knowledge of a return home
- Agency failed to ensure accurate completion of all pertinent components of the discharge comprehensive assessment with 2 days of the agency knowledge of the patients return home
- Agency failed to ensure accurate completion of all pertinent components of the resumption of care with 48 hours of the agency's knowledge of return home from an inpatient stay
- Resumption of care comp assessments not completed

G-341

- Timely completion of the Transfer OASIS not done within timeframes
- Late completions of d/c comp assessments
- Agency failed to ensure accurate completion of all pertinent components of the transfer assessment with OASIS data within the required timeframe
- Agency failed to ensure accurate completion of all components of the discharge comprehensive assessment within the required timeframe. OASIS not locked according to agency policy or federal regulation
- Agency failed to ensure completion for a transfer assessment within the required timeframe
- Agency failed to ensure accurate completion of all pertinent information of discharge comprehensive assessment. Agency did not have a weight documented
- Policy stated agency nurse would conduct and complete comprehensive discharge assessment in required time frame. Agency notified patient to say home infusion company was going to contact the patient that agency services were going to be d/c as no need for nursing services

G-342

- The conditions of participation require all OASIS data be integrated into each comprehensive assessment used by the agency. The agencies electronic computer system separated the documentation of the comprehensive assessment clinical findings into two documents

Emergency Preparedness Tags

E-017

- Late completions of d/c comp assessments
- Agency failed to ensure the completion of emergency plans in the event of natural or man-made disasters based on a risk assessment conducted as part of the comprehensive assessment.
- Agency failed to ensure the completion of emergency plans in the event of natural or man-made disasters based on a risk assessment conducted as part of the comprehensive assessment

E-019

- The Emergency Disaster policy failed to include any information regarding the evacuation of homebound patients

E-037

- Agency failed to ensure training in emergency preparedness policies and procedures to all individuals providing services under arrangement
- Agency did not provide emergency preparedness training on policies and procedures to all staff and individuals providing services under arrangement
- Agency failed to provide training in emergency preparedness policies and procedures to all staff and individuals providing services under arrangement placed agency patients at risk for not having trained and prepared staff to assist them in the event of an emergency