Iowa Center for Home Care
HHA Survey Review G-Tags
1st Quarter 2019

Total # of reports: 16
Recertification surveys: 15 (0 deficiency free)
Complaint: 0 (0 deficiency free)
Extended: 1 (0 deficiency free)
Revisits: 5 (4 deficiency free)
Inability to competize = 4
Validation survey = 0

Old CMS description of G-tags

New G tags

G-Tags cited by Iowa Department of Inspections and Appeals

G482
- Failure to investigate patient complaints of missing items. Agency had 6 complaints in past 6 months. No documentation of any investigation or resolution for complaint of theft.

G484
- Failure to document and maintain evidence of resolution of the complaints

G514
- Failure to provide an initial assessment visit within 48-hrs putting agency patients at risk for not having immediate care needs met.

G516
- Fail to provide initial assessment visit in 48 hours of receipt of referral/ and or return home.

G520
- Failure to complete comprehensive assessment within 5 calendar days after the SOC
- SOC comprehensive assessment was not electronically signed by day 5; exceeded 5-day timeframe by 2 to 10 days

- Fail to accurately/thoroughly complete SOC comprehensive assessments in timely manner increased potential patients might not receive care in manner to meet individualized needs.

G528

- Fail to ensure accurate/thorough completion of all pertinent components of comprehensive assessments. Agency documentation of reported height/weight not actual height/weight.
- Agency failed to ensure accurate and thorough completion of all pertinent components of comprehensive assessments. Patient was diabetic but the assessment failed to identify the patient has any endocrine issues. Nurse failed to accurately describe the wound. Patient had order to measure abdomen and the nurse did not do it.
- Fail to ensure accurate/thorough completion of all pertinent components of comprehensive assessment. Wound assessment didn't have depth noted. Patient who was diabetic did not have metabolic status assessed.
- Agency failed to include an individualized assessment relating to the patient's current health status. The resumption of care assessment lacked any description of the wound between the fourth and fifth toe, lacked any description of the lateral wound.
- No ht/wt on comprehensive assessment; pt had secondary dx of COPD but assessment failed to identify COPD as part of respiratory assessment;
- Fail to accurately/thoroughly complete comprehensive assessments increased the potential that patients might not receive services in a manner to meet individualized patient needs.
- Failure to accurately/thoroughly complete comprehensive assessments increased potential that patients might not receive services in a manner to meet individualized patient needs.

G536

- Fail to complete drug regimen review including all required components, with each discharge assessment.
- Agency failed to complete a drug regimen review of all the patient's current medication with the completion of each comprehensive assessment. Clients medication listed on the POC did not match what the client was actually taking in the home.
- Fail to complete drug regimen review, including all required components, with each comprehensive assessment. DRR failed to identify duplicate blood pressure and blood thinner medications.
- Agency failed to accurately identify all medications taken by the client with each comprehensive assessment. All of the over the counter medications were not listed on the POC. Medication list did not have the time of administration when taking every day.
- No DRR completed on ROC. Medications found in the home that were not on the Medication list. Discharge comprehensive assessment with no DRR.
- No times for administration; lacked dosage; some meds on HH med list were not found on the Assisted Living facility MAR; Some meds were on AL MAR but not on the HH med list; med on HH med list that had been discontinued as reported by client in the home.
- No times of day for meds; DRR lacked identification of duplicate meds (acetaminophen and Tramadol); duplicate bowel meds, duplicate diabetic med, duplicate vitamins; doses incorrect on HH med list according to client; med on HH med sheet not taken for 1 month as reported by client.
- Failure to ensure medications reviewed of each regimen review are current and accurate and failure to identify actual/potential for unidentified medication interactions and side effect risks to patient at the time of each comprehensive assessment.

- Fail to ensure medications reviewed at time of each drug regimen review current/accurate and failure to identify actual/potential concerns increased the potential for unidentified medication interactions and side effect risks to the patient at the time of each comprehensive assessment.
- Duplicate medications- lacked information of specific side effects; Resumption of care assessment lacked documentation of drug regimen review, D/C assessment lacked identification of duplicate medications. POC included duplicate medications.
- Supplement client had by bed was found by surveyor during home visit that was not on med list. staff says didn't know client used it. Meds on list that client no longer uses;
- DRR did not meet all 5 elements: duplicate meds, ineffective drug therapy, side effects, noncompliance, significant side effects. No documentation of duplicate meds.

G546

- Fail to ensure timely completion of recertification comprehensive assessment between days 56-60.
- Fail to complete all required components of recert assessments between day 56-60 for multiple patients.
- Fail to complete recert comprehensive assessment in timely manner (last 5 days of 60 days) Cert ended and recert assessment completion DRR dated one1 day late. DRR completed 2 days late for recert on 2 other records and 1 day late on another
- Recerts not electronically by day 60; some initiated between day 56-60 but not signed as complete by day 60.
- Comprehensive Assessment not signed and completed within the 60 days (5-day window).
- Failure to ensure accurate and thorough complete recertification comprehensive assessments in a timely manner increased potential that patients might not receive services in a manner to meet individualized patient needs.

G548

- Agency failed to ensure accurate completion of all pertinent components of resumption of care comprehensive assessment within 48 hours of agency's knowledge of return home.
- Agency failed to ensure accurate completion of all pertinent components of the resumption of care within 48 hours of agency knowledge of return home.
- ROC not completed within 2 calendar days of patient's return home. ROC was 1 day late.
- Fail to complete ROC w/in 48 hrs. of patient's return home from hospital admission of 24 hrs. or more for reasons other than dx tests, ROC completed 1 day late, DRR with ROC was 2 days late
- ROC not completed within 48 hrs. of patient's return to the home from a hospital admission of 24 hrs. or more for reasons other than diagnostic tests or on physician ordered resumption date; Exceeded requirement by 3 to 11 days.
- Fail to complete resumption of care comprehensive assessment in timely manner increased potential that patients might not receive services in a manner to meet individualized patient needs.
- ROC not completed within 48 hrs of dc from hospital stay of 24 hrs or more; ROC started within 48 hrs but not completed within 48 hrs.

G570

- Failure to ensure all supplies/equipment/medications/treatments were included on each patient's POC. Agency failed to include all verbal orders in a working plan of care. Agency failed to alert physician to changes that may suggest a need to alter the POC.
- Failure to ensure each patient received services that were established by a doctor.
- No current working POC-verbal orders not included in. Supplies, equipment, meds missing, failed to integrate all services on POC.

G572

- ARNP provided diagnosis for foot ulcer and treatment orders, clinical record did not include approval from physician. Orders signed by a wound nurse at wound clinic but not approved by physician. LPN identified a fall resulting an abrasion to knee, she reported to case manager and to ARNP but not a physician.

G574

- Fail to ensure accurate completion of all pertinent components of POC, including supplies/equipment used by patient. Failed to identify accurate meds used by patient.
- Failed to complete accurate plans of care with current orders. POC lacked hand held shower, scale blood pressure cuff and hr-rise toilet seat, ramp, wheelchair.
- Agency failed to ensure accurate completion of all components comprising the POC, including all physician orders supplies/equipment used by patient. POC did not have mediplanner, glucometer, foot brace. Wound care orders did not show up on POC. POC lacked orders for nurse to set up pills. Client's meds taken in home did not match POC.
- Agency failed to ensure accurate completion of all components comprising POC. Not all DME was listed on POC- lift chair. POC did not have a stop date on antibiotic. Not all components of DRR done. Life line pendant system not listed on the POC
- Agency failed to ensure accurate completion of all components comprising the POC, including all physician orders. POC lacked patient's risk for emergency room visits and hospital re-admissions or any interventions to address underlying risk factors medication order failed to specify a frequency for use. POC failed to include advanced directives.
- Fail to list all DME on POC: incontinence briefs, elbow pads, roho cushion, chux pads. The patients POC lacked any wound care orders, simply stating "see order for wound care".
- Fail to maintain complete/accurate POC. Did not list all of DME- brace/orthotic; ERS, incontinence briefs. Clinical record included documented that client had MPOA, the MPOA signed all admission forms but POC did not identify all of the patient's advanced directives.
- POC had orders for medicated wash to lower legs which was not being used in home; had order for antibiotic which was no longer being taken; POC had order for MiraLAX prn but did not specify under what circumstances patient should use; failed to specify under what circumstances patient should use antifungal prn powder; DME not completely listed including grabber, incontinence pads, mediplanner, pulse oximeter, compression hose (PT listed these in notes), hand held nebulizer seen on a shelf, glucometer and supplies.
- Failed to ensure accurate completion of all components comprising the POC, including all supplies/equipment used by the multiple patients.
- Failure to maintain complete and accurate POC with current orders placed the patients at risk to not receive services, medications, and/or treatments according to assessed needs and physician's orders.

- POC did not include-frequency for treatment, DME-bath chair, scale, sock aid, long handled shoe horn. Medication order did not stape specific location for application of topical medication. Disposable incontinent briefs and disposable bed pads not on POC.

G576

- Fail to update POC with all new physician orders. Interim physician orders on updated POC.
- Agency did not have all verbal orders recorded in the POC.
- Agency failed to update the POC with all new physician orders.
- Failed to maintain working POC for patients; update working POCs with any new verbal /interim physician orders.
- Plan of care not updated with verbal orders. Therapy orders post SOC-POC not updated in POC. D/C of aide services post SOC-POC not updated. All services ordered post SOC-POC must be updated to include or discontinue.
- Agency had original POC, but interim orders were not on working POC.
- All orders not on POC.
- No documentation of updated POC.

G580

- Agency failed to provide wound care only as ordered by the physician. POC did not have an order for a dressing the nurse applied in the home. POC has an order to check a pulse ox with each visit and the nurse's notes did not have a pulse ox result.
- Nurses performed wound care without orders. Failure to measure wounds weekly.
- Did not have orders obtained by physician for OTC meds-(not on POC).Med Profile reflected med-but not POC.
- Medication set up done by agency nurse-and nurse stated "med set up completed POC did not include-frequency for treatment, DME-bath chair, scale, sock aid, long handled shoe horn. Medication order did not state specific location for application of topical medication. Disposable incontinent briefs and disposable bed pads not on POC did not include aspirin as on medication regimen. Surveyor asked" med set up completed about it, then staff and patient looked for Aspirin. Staff contacted family and explained difference between aspirin and acetaminophen (as patient only had acetaminophen in home. Staff went and got Aspirin for patient and completed med set up. Start of care for therapy out of 48 hours compliance with physician order. Order for patient temperature to be taken no documentation of temperature readings or reason nurse failed to check temperature. No order from physician to provide wound care to popped blister on patient.
- Orders for SN to check VS each visit; no documentation of temp or why failed to be checked

G590

- Fail to report changes in patient clinical findings to physician as directed on POC. Client had orders to report blood sugars if too high or too low and physician did not receive a call.
- Physician not notified of change in patient condition-patient aide reported wheezing and coughing-no follow up by nurse to physician regarding change in condition.

G596

- VA doc returned POC crossing through some of the meds and writing in others, wrote in "not on current med list" Added Albuterol inhaler.

G606

- Coordination of care conferences not documented between therapist and Nurse.

G608
- Coordination of care conferences not documented between therapist and Nurse.
- Failure to assess wounds, including measurements, may result in unidentified worsening of wounds or unidentified need to alter wound treatment.
- Agency failed to accurately identify patient charts to indicate advanced directives; DNR sticker on chart of client who requested to be a full code.

G612
- During home visit, client reported not having written info from the agency which indicated the agency provided nursing services for med set up and included the clinical manager's name.

G616
- Patient had no copy of current medication list provided by agency.
- No medication list in patient's home. No updated medication list in home.
- No medication list in the home; only med list in the home was from the VA

G618
- Agency failed to provide the patient and caregiver with a copy of written instructions outlining any treatments to be administered by the agency personnel and personnel acting on behalf of the agency. Folder in pts. Home did not have treatment orders.
- During home visit client reports that there is nothing in writing in the home about what services HH will provide (med set up).

G620
- Agency failed to provide patient and caregiver with a copy of written instructions outlining any other pertinent instructions related to the patient's care and treatments that the home health agency will provide. The folder in the home lacked documentation of instructions provided by the skilled nurses and the interventions provided ty the speech therapist.

G622
- Fail to provide agency patients written contact information for agency's clinical manager.

G640
- Did not have a QAPI plan with all components

G642
- No documentation of QAPI program reviewed by governing board-No evidence QAPI program initiated.

G644
- QAPI not approved by governing board

G648
- No QAPI in place

G650
- No QAPI in place-Incidence, prevalence, etc.

G652
- No QAPI in place-immediate correction

G654
- No QAPI in place-track adverse patient events
- Failure to track and analyze adverse patient events in order to implements preventive actions placed agency patients at risk for recurring adverse events with negative outcomes.

G656
- No QAPI in place-Improvements are sustained

G658
- Performance improvement projects

G660
- Governing body ensures QAPI -expectations, implementation, maintenance, defined. Fraud and abuse.

G682
- Nurse sanitized hands, gloved, but continued to touch other items before doing med set up
- Infection control P&P lacked documentation that re0usable med equip such as BP cuffs and stethoscopes must be cleaned/disinfected prior to use on another patient and during home visit, staff (PT) did not clean after using on client and before placing back into bag. Nurse was setting up meds and touched papers, laptop and mouse, and patients' bare shoulder with her right fingers and continued to set up meds without cleansing her hands.

G684
- Fail to provide care in accordance with agency expectations, accepted infection control standards of practice. RN washed hands, touched multiple things, then filled mediplanner.
- Agency failed to ensure staff provided care in accordance with agency expectations and accepted infection control standards of practice for staff. Nurse did not change gloves and wash hands appropriately as to follow agency policy with a wound dressing change.
- OT did not clean equipment (pulse ox) after use and told surveyor she had not received training on infection control.

G702
- Agency failed to assure clinicians followed agency policies and procedures when providing wound care. The skilled nursing note lacked documentation of wound.
- Agency failed to assure clinicians followed agency policies and procedures when providing wound care. The skilled nursing note lacked documentation of wound.

G706
- Agency clinicians failed to include measurements of wounds, including length, width, depth.
- Wound measurements not done weekly.

G710

- Agency failed to ensure skilled professionals provided care as ordered by the physician. Patients medication was not accurate to what she was actually taking.
- Fail to ensure skilled professionals provide care as ordered by physician in the POC. Documentation lacked pts weight. Documentation lacked assessment for pain with intensity and location.
- Agency failed to ensure skilled professionals provided care as ordered by the physician in the POC. Skilled visit note identified the patient had diabetes but lacked any endocrine assessment. Agency did not have all medications listed in the home on the POC.
- Agency failed to ensure skilled professionals provided care as ordered by the physician. Orders were for pulse ox with each skilled visit, but the notes lacked a pulse ox result.
- Failure to provide care in accordance to physician's ordered Plan of Care placed patients at risk to not receive safe, individualized and consistent care designed to meet each patient's healthcare needs. Failed to update POC; Clinical record lacked a physician's order for nurse to set up medications.
- Weight on each visit not completed; PT ordered 2xwk, only provided once with no documentation as to why; failure to obtain wound orders for new wound dressing that was applied. INR orders for Mondays but drawn on Tuesdays with no updated orders. Agency policy is SN to provide all wound cares (although aides were performing).

G718

- Failure to effectively coordinate all skilled services placed agency patients at risk for inadequate or inappropriate care. Clinical record lacked physician's order for blue lotion or evidence the physician was contacted regarding the use of blue lotion. Clinical record lacked documentation that the nurse notified the patient's physician of the patient's use of a different amount of oxygen than the about the physician had ordered.

G724

- Lack of documentation of any supervision performed by a RN and LPN.

G750

- HHA care plan directed the aide to provide supra pubic cath care; aides' personnel file lacked documentation that a RN had observed HHA competently perform suprapubic cath care prior to assigning her this task.
- HH aide services-14-day Supervisory visits of aide, Competency satisfactory with extra skills

G768

- Agency failed to ensure home health aides assigned to perform tasks requiring extra skills where competized before performing the task on the patient.
- Personnel file included documentation of competency for reading and recording TPR in a lab setting, no direct observation documented.
- Testing that should be performed on patient was performed in lab setting
- Aide competency skills testing done in lab not on patient. Failed to complete bed, sink, and tub shampoo. No skills check on applying medicated powders or creams.

G772

- HHA personnel file contained documentation of completion of skills testing for shaving, cath care, changing a cath bag and changing ostomy bag but failed to identify the location where competency testing occurred.

G798

- Agency failed to provide individualized and specific written patient care instruction by a RN for HH aide. Aide careplan and oral care and shaving PRN and did not specify under what circumstance the aide was to provide those cares.
- Agency failed to provide individualized and specific written patient care instructions from a RN to agency home health aides.
- HHA assignments and duties directing the care provided by aides. EX: "cream to skin folds as directed by patient" - lacked documentation of any cream used. "application of brace as requested" lacked documentation of type brace.
- Aide care plan had instructions for aide to complete skin care and foot care; care plan failed to provide patient-specific instructions to aide on how to complete these tasks to meet needs of client- type of skin care; nail care and cath care- no specific instructions.
- Aide poc directed aide to shampoo client's hair but this was not currently being done; RN failed to update aide poc when staff became aware patient did not require shampoo at each aide visit
- Aide care plans not in place. Used contracted staff; agency did not comp or assign aides-contact agency did which was not within agency policy. Aide care plans not specific or individualized.
- Failure to ensure agency registered nurses provided patient specific written instructions directing the care provided by the agency's home health aides for each patient increased the risk agency patients would receive inappropriate or inconsistent HH aide services.
- Lack of individualized care plan for aide.
- Aide care plan said to complete shower or sponge bath but did not say how to decide which to do; ordered hair care but did not specify what type of hair care; ordered skin care but did not say what kind of skin care.
- Aide care plan lacked documentation of tasks performed as directed by the Case Manager.

G800

- Failed to ensure home health aide provided services according to home health aide written assignment. The aide lacked documentation of why a task on the POC did not get done.

G808

- No documentation of supervision for 15- 61 days; should have been done every 14 days.
- Missed supervisory of aide visit.

G814

- Missed supervisory of aide visits.
- Fail to ensure RN completed HHA supervision at least every 60-days.
- One chart reviewed said supervision completed by aide was not present.
- Not all HHC aides who provided care during the previous 60 days were not supervised; agency only supervised 1 home care aide for the 60 days.

G818

- Aide supervision-not done in presence of aide.
- For clients receiving HHA services and skilled services, clinical record lacked supervisory forms that addressed aide's communication process, competency wit tasks provided, compliance with

infection prevention and control, and honoring patient rights. Supervisor note lacked identification of tasks performed by the aide and directly observed by the RN.
- SV note did not document all elements of HCA supervision.

G848
- Agency allowed an employee to work without completing the required criminal and dependent adult abuse and child abuse background checks.
- Criminal back ground check not completed prior to hire date or past 30 days of receipt of background check.
- Agency allowed employees to work without criminal background check, dependent adult abuse, and/or child abuse checks; this included subcontracted therapy staff.

G962
- VA doc returned POC w/ meds crossed out, new med written, time of day added. Clinical record lacks documentation that agency staff were aware of handwritten revisions to POC.

G1008
- Did not complete d/c summaries and sent to physician caring for patient and other health providers within 5 days; Authenticate hand written documentation.

G1012
- Agency failed to have all interim physician order signed by the physician. Clinical record did not have an order for PT/INR which the nurse took. Agency did not have an order for some of the over the counter medication the pt. was using.
- Agency failed to ensure all interim physician orders were signed by a physician.

G1014
- Fail to ensure clinical record included pertinent documentation of HH aide interventions. Aide documented patient weight on calendar in home which agency didn't have in chart.
- Agency failed to ensure the patient's clinical record included accurate and specific documentation of interventions. Visit note failed to identify any blood sugar reading.
- Aide check marked that she shampooed client's hair, but it was really done by someone outside of the home. Aide said she thought by checking this it meant the shampoo was received by client but not provided by the aide; lack of wound measurements for first 2 weeks after SOC; At some visits, wound measurements were not complete; there was a wound depth but no length and/or width.
- Failure to ensure patient's clinical record included accurate documentation of interventions placed agency patients at risk for not receiving correct interventions and for other disciplines providing services to have unclear or inaccurate information regarding the patient's condition.
- Aide assigned to assist with walker, chair lift. Documentation failed to signify if assisted with one or the other or both. Documentation from therapy notes past policy timeline (contracted therapy service). Missing therapy documentations. Wound measurements not complete - missing depth. SOC lacked wound measurements.

G1022

- Fail to complete/send transfer summary to physician or other health care professionals responsible for providing care to patient while in a health care facility within 2 business days of knowledge of the occurrence.
- Fail to complete/send transfer summary to physician or other health care professionals responsible for providing care to patient while in health care facility within 2 business days.
- Fail to complete/send transfer summary to physician or other health care professionals responsible for providing care to patient while in health care facility within 2 business days.
- Fail to complete/send a discharge summary to physician or other health care professional responsible for providing care to the patient.
- Clinical records lacked evidence that Discharge and Transfer summaries were sent even though it was checked on the summaries that physician was notified of its availability.
- Failure to send the physician and other health care professionals a summary of the patient's care while receiving services from agency in a timely manner may result in inadequate or inappropriate follow-up after transfer.
- D/C transfer summaries-did not meet time frames.
- D/C summary not sent to physicians within five days.
- Clinical record lacked documentation that a transfer summary was sent.

G1024

- Agency failed to ensure authentication of hand-written entries made in each patient's clinical record included the employee's signatures.
- Authentication failed to ensure clinical record (hand written) entries included employee's signature, title, date and time of signature.
- Failure to maintain timely, accurate and appropriately authenticated clinical record documentation increased risk that agency staff provided services without up to date information related to patient's condition and decreased ability of agency staff to communicate effectively in order to coordinate patient care.
- Med regimen lacked date and time of signature. Home health aide note had staff initials but no staff signature. Multiple handwritten signatures lacked title, date and time.
- PT and OT eval lacked the therapist's handwritten signature, title, date, and time; signatures lacked a date and time.
- Failed to ensure authentication of all hand-written entries made by HHA in each clinical record to include aide's signature, date and time of signature.

G1026

- Locking Oasis, then changes required after locking; nurse unlocks document, makes the change, relocks Oasis, again print the document/sign, placing document in patient's clinical record/destroys original, backdates new document making it appear as if it is the original.

G1028

- Patients' charts were not stored per policy in no locked file cabinets and were accessible by other employees of County -not in-home health.

E-007

- Must develop and maintain EP plan must be reviewed, updated at least annually.

E 009

- Agency had no EP

- Failure to have a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness official's efforts to maintain an integrated response during a disaster or emergency situation potentially placed agency patients at risk for not receiving needed assistance during or due to an emergency situation.
- No policy or process for cooperation or collaboration with local, tribal regional, State and Federal emergency preparedness officials.

E 017

- Agency failed to ensure the clinical record included a copy of the patient's individualized emergency plan developed as part of the comprehensive assessment.
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- Agency failed to ensure the clinical record included a copy of an individualized emergency plan developed as part of the comprehensive assessment.
- Failure to maintain a copy of patient's individualized emergency plan developed as part of comprehensive assessment. Did not keep a copy for agency record and did not update at each comprehensive assessment.
- Recert assessments lacked documentation indicating the nurse reviewed the emergency plan for continued accuracy. During a home visit the nurse presented the agency's folder in home to surveyor but there was no copy of the individualized emergency plan. On another chart the SOC was prior to regulation for emergency plan but recerts done after this was effective the recert did not include an emergency plan. ROC did not contain documentation that emergency plan was reviewed; at recert it said that emergency plan was reviewed but no individualized plan was found in the clinical record.
- No individualized emergency plan in the home, agency provided generalized emergency preparedness info as part of a booklet give to each patient in admission packet; agency stated they had discussed an individualized emergency preparedness plan with patient but no copy given to client; Client admitted, but did not receive copy of emergency plan until later when staff visited with surveyor; no emergency plan found in client's folder in home; clinical record did not have documentation of review of emergency plan at time of recert.
- Failure to ensure the agency maintained a copy of the patient's individualized emergency plans as developed as part of the comprehensive assessment placed patients at risk for staff being unaware and unprepared to respond in a timely and effective manner to potential health and safety hazards the patient may encounter.
- Agency had no EP.
- Failure to ensure agency maintained a copy of patient's individualized emergency plans as developed as part of comprehensive assessment placed patients at risk for staff being unaware and unprepared to respond in a timely and effective manner.
- Clinical Record did not have a copy of patient's Individual EP developed as part of the Comp Assessment. No evidence of EP discussion with patients.
- Agency had individualized emergency plans in office but were not putting a plan into written format to keep in the client/cg home.
- Agency provides booklet in admission packet; staff may make notes in column with specific info for patient but no other written info.
- Agency failed to ensure the clinical record included a copy of the patients' individualized emergency plan developed as part of the comprehensive assessment.
- Agency failed to ensure the clinical record included a copy of the patients' individualized emergency plan developed as part of the comprehensive assessment.
- Lack of documentation or a copy of an individualized emergency plan with patient.

E-019

- Agency failed to ensure the development of a procedure to inform state and local officials of homebound pts. in need of evacuation due to an emergency situation.
- Failure to have procedures in place to inform state and local officials of homebound patients in need of evacuation due to an emergency situation.
- Failure to have procedures in place to inform State and local officials of homebound patients in need of evacuation due to an emergency situation potentially placed at risk for not receiving needed assistance during or due to emergency situation.
- Agency had no EP.
- Failure to have procedures in place for how to inform State and local officials of homebound patients in need of evacuation due to an emergency situation potentially placed hospice patients at risk for not receiving needed assistance during or due to emergency situation.
- Agency lacked documentation of procedure for notification of appropriate agencies and officials of homebound patients in need of evac in case of emergency.
- Failed to have procedures in place on how to inform state and local officials of homebound patients is need of evacuation due to an emergency situation.

E-021

- 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.
- Agency failed to ensure development of written policy/procedure to inform state and local officials of any on duty staff and patients they are unable to contact in the event of an interruption of services related to an emergency.
- Agency did not have documentation that there was a written P&P directing agency staff to notify the appropriate officials of the inability to contact on duty staff and patients.

E 024

- No written policy and procedure for process and role for integration of State and federally designated health care professionals to address surge needs during an emergency
- Agency had no EP.
- Failure to ensure the HHA developed policies and procedures to address the use of volunteers or other emergency staffing strategies during an emergency placed agency patient at risk for not having help to meet safety and health care needs in the event of a man made or natural disaster.
- Lack of policy and procedure for using volunteers in emergency.
- Failure to develop policies and procedures to address use of volunteers or other emergency staffing strategies during an emergency.

E 031

- Failure to ensure an emergency preparedness plan included a communication plan that complied with federal, state and local laws during a disaster.
- Agency had no EP.
- Lacked policy for cooperation/collaboration with Tribal, regional, state and federal officials

E 032

- Agency had no EP.
- Failure to develop/maintain an emergency preparedness plan included primary and alternate means of communication with agency staff and federal, state, tribal, regional and local

emergency disaster management agencies during a time of disaster or emergency which could lead to poor client outcomes in the event of an emergency disaster.

E 033

- Agency had no EP.
- Failure to develop and maintain an emergency preparedness communication plan that included a method of sharing information and medical documentation for agency client to maintain the continuity of care during a time of disaster or emergency which could lead to poor client outcomes in the event of an emergency/disaster.

E 034

- Agency had no EP.
- Fail to develop/maintain preparedness communication plan to include means of providing information re agency's occupancy, needs, ability to provide assistance to authority having jurisdiction, incident command center, or designees, during time of disaster/emergency which could lead to poor client outcomes in event of emergency/disaster.

E 036

- Agency failed to ensure the agency provided training in emergency preparedness policies and procedures to all contracted staff.
- Agency failed to ensure all contracted therapists received training in the agency's emergency preparedness policies and procedures.
- Agency had no EP.
- Training and testing EP not done.

E 037

- Fail to ensure training in emergency preparedness to all existing staff consistent with their expected roles.
- Failure to ensure training in emergency preparedness for all individuals providing services under arrangement annually.
- Contracted staff were not trained in emergency preparedness policies and procedures.
- Agency did not provide emergency preparedness training for any contracted employees.
- Agency did not provide emergency preparedness training/review of the Disaster Plan for marketing/sales and "office staff".
- Agency had no EP.
- Agency had documentation of emergency preparedness training for all directly hired staff (RN, HCA, and office staff) but lacked documentation of annual training for any contracted physical therapists, occupational therapists, speech therapists).