Iowa Center for Home Care
HHA Survey Review G-Tags
3rd quarter 2017

Survey type: 8 recertification surveys (0 deficiency free), 0 extended (0 deficiency free), 1 complaint (0 deficiency free), 5 revisits (2 deficiency free) 2 inability to competize (0 deficiency free) and 0 validation survey (0 deficiency free) recently reviewed by the ICHC Survey Results Committee are listed below with narrative. There were 107 total deficiencies.

Total # of reports: 16
Total # of surveys deficiency free (revisits) or complaints unsubstantiated: 2

Average # of deficiencies

All = 6.69	**Complaints = 1**
Recertification = 8.1	**Inability to competize = 2**
Extended = 0	**Revisits = 0**
Validation survey = 0	

Survey Summary **and be sure to see page 9: compliance tips**

G-Tags cited by Iowa Department of Inspections and Appeals

CMS description of G-tags

G-113

- Agency failed to make sure patients received written identification of the amount of payment for home health services would be paid by Medicare or any other 3rd party payor and the potential out of pocket expenses the patient could expect to pay
- Patients failed to receive from agency written identification of the amount for home health services would be paid by Medicare or any other third party payor and the potential amount of out of pocket expenses; patient 1: client informed consent form documented plan to bill Medicare for skilled nursing services but lacked documentation on how much out of pocket expenses could be expected (x2) also for Blue Cross/Shield

G-114

- Agency Fee Form did not include information on potential "out of pocket" expenses for clients

G-116

- Home Health Hotline: form failed to clearly specify that toll-free hotline was for all agency patients, regardless of payor source, and included hours of operation

G-118

- Agency allowed 1 0f 6 people hired since 5/20/14 work without evidence of completion of the required dependent adult abuse and child abuse background checks within 30 days prior to hire
- Criminal background/dependent adult abuse checks not completed within 30 days before hire, employee was to start Aug. 1, but was delayed until Aug. 22, background check expired.

G-121

- Nurse returned soiled thermometer, stethoscope, BP cuff, and oximeter to nursing bag without cleansing during a home visit; Nurse continued to wear contaminated gloves while cleaning dirty equipment and returning them to clean cases and nursing bag

G-143

- Coordination of Patient Services: No order/communication with physician for Tylenol PM; did not follow policy regarding obtaining new orders and documenting them in a timely fashion; did not follow policy for RN to co-sign LPN orders; wound care d/c'd with no order from physician; no documentation to document that nurse contacted physician to notify of pt refusal of wound care; clinical record lacked evidence of completion of ordered ST eval; LPN noted s/s of UTI in note but no evidence that she communicated this to RN Case mngr or physician;

G-158

- Acceptance of patients, POC, med super: Failure to follow Physician ordered POC and/or notify physician of need to change planned visit freq; Home health aide visits were not delivered as ordered and physician not made aware of these missed visits; no evidence of physician notification of missed SN visits
- Care plan lacked reasons for PRN visits

G-159

- Agency failed to ensure the accurate completion of all care plans and/or failed to make sure the Plan of Care contained current, accurate information. Order failed to specify under what circumstances the agency might make a prn visit. Discharge plan failed to say when the agency planned to discharge the client. Not all DME supplies listed on POC. Medication ointment did not list where to apply on the body. Not all over the counter medications were listed on the POC. No physician order for the home health aide to apply boots to feet.
- Agency failed to ensure the accurate completion of all components comprising the POC and/or failed to ensure the POC contained current information. POC failed to include wound vac supplies.POC lacked discharge plan. Medication orders lacked dosage of medication. POC did not have all the DME that was in the home. POC lacked inclusion of rehab potential.
- Plans of care: order for Hydroxyzine failed to include reason for administration; ointment, failed to include which parts of body needed application; failed to include how often patient was to take medication for constipation (x2) ointment prescribed for itching/rash, failed to document what body part to administer to (x4)
- Plan of care: order lacked physician approved frequency for maximum times the patient can take safely in one day; plans lacked discharge plan, plan included "oxygen" as equipment used by the patient but the plans lacked an order indicating how many liters per minute were approved by the physician; care plan included wound vac three times daily as needed, but lacked specific wound vac settings suction approved by physician; patient lacked discharge plan; plan called for social worker visits but lacked frequency; patient had lifeline, told surveyor had it for "about a year," care plan documentation
- Plan of care: hospital bed, mechanical chair lift, reacher and gait belt, hand-held shower, mediplanner and disposable incontinence products were not listed on care plan; multiple instances of drug administration requirements did not include under what circumstances to take; failed to identify which eye(s) needed eye drops, care plan failed to include sock aid and reacher; shower chair and grab bar not included on care plan; long-handled shoe horn not on care plan; discharge

plan included "family/friend will assist client to manage care but failed to identify under what circumstances the agency planned to discharge the patient

- Care plan lacked evidence of frequency, route and duration, no evidence of permitted DME equipment
- Missing DME, including a shoe horn, cited multiple times, heating pad, missed taking off homebound on computer generated forms
- Incorrect dose of insulin as reported by client listed on Plan of Care; no physician orders for aide to do simple dressing changes, do catheter care or empty catheter bag; No directions on POC for use of nasal spray, prn pain medications, prn HS medication
- Incentive spirometer, mediplanner, walker owned by no used and shower stool used by client not listed on POC; medications were on POC that had been dc'd according to client; orders for lab draw did not specify INR even though it included orders for the lab draw and a Coumadin dose

G-170

- Agency failed to ensure nurses provided care as ordered. Patients order for weekly B/P checks not found in chart
- Wound care not provided, wound not covered by non-adherent dressing or wrapped with an ace wrap as part of the outer dressing as ordered by physician
- Agency failed to provide skilled nursing services per care plan: care plan lacked documentation RN filled insulin syringes for one week; RN failed to record patient's weight every week as needed (3X); RN was to ensure gastrotube was secured by ensure balloon holding had 5 cc fluid in it, nurse notes lacked documentation of 5 cc; nurse notes failed to document Setopress wraps applied; notes lacked documentation that RN contacted physician for a specific treatment order prior to applying Mepilex to wound; nurse notes listed injection required but not completed due to patient not picking up prescription from pharmacy

G-172

- Agency failed to ensure the accurate completion of all care plans and/or failed to make sure the Plan of Care contained current, accurate information. Order failed to specify under what circumstances the agency might make a prn visit. Discharge plan failed to say when the agency planned to discharge the client. Not all DME supplies listed on POC. Medication ointment did not list where to apply on the body. Not all over the counter medications were listed on the POC. No physician order for the home health aide to apply boots to feet.
- Patient wound was covered by Band-aid, surveyor observed Band-aid did not cover all of wound, band aid was soaked with brown, dried drainage, staff removed band aid and cleansed wound but did not measure the wound
- Agency failed to make sure the agency's nurses adequately reevaluated the patient's status and response to care. Comprehensive assessment lacked specific location of wounds, had no wound measurements or any other description of the wounds
- Skilled Nursing Services: Failed to provide SN care as ordered on POC….no documentation of ostomy care, only documentation was of appearance of stoma and skin; nothing about wafer or appliance; No documentation of ordered wound care; pt refused wound vac treatment as was ordered but no documentation that physician was notified of pt refusal
- Duties of the RN: Agency failed to show that nurses adequately re-eval pt status and response to care; no documentation of wound care, wound measurements
- Nurse failed to establish a baseline of bowel and bladder function; no clinical documentation of nurse findings of abnormally high blood sugar levels, no pain rating for baseline pain assessment
- Inconsistent wound measurements that did not follow agency policy
- Agency nurses did not measure wounds according to policy (measuring length, width and depth weekly)

G-173

- Duties of RN: multiple medications discrepancies, patient reported not taking hydrocodone per physician's orders "not for several months;" other multiple instances of patients discontinuing medications; care plan not updated to monitor vital signs, SP02, temp, weight once a week as needed

G-174

- Nurse did not perform specialized assessment of status wounds, did not measure wound's length, depth, width

G-176

- Agency failed to make sure RN's coordinated with physicians. The 60 day summary to the physician lacked any documentation which reported to the physician the number of wounds, any measurements, or any further description.
- Agency failed to make sure the nurses coordinated with physicians. Skilled visit note showed a weight gain of 6lbs. In 4 day and the doctor was not notified. Patient had a 27 lb. weight loss in 4 weeks, and the patients electronic clinical record lacked documentation of physician notifications
- Nurse did not inform physician of wound changes, including assessments
- Staff did not communicate with physician patient status per parameters of agency policy; patient discharged from hospital past recertification period, nurse completed ROC instead of D/C and readmitted without physician knowledge; no documentation showing blood sugar logs sent weekly to physician; missing orders on care plan

G-179

- LPN did not perform wound measurements and not provide care per policy

G-202

- Agency failed to maintain sufficient documentation whether skills competency was demonstrated in home setting with a patient or in a laboratory setting using a pseudo-patient

G-210

- Agency failed to ensure a RN documented which specific skills the aide completed basic skills competency evaluations. RN did not document the competency evaluation of extra skills assigned.
- Agency failed to document whether the basic competencies were evaluated in lab setting using a pseudo patient or in a home setting while being performed on an actual patient
- HHA training documentation Staff completed basic skills competency testing for tub, sponge, shower bath, competency evaluation lacked documentation which specified which skill or skills the aide had performed for the competency testing
- Aide personnel records failed to define whether skills competencies were assessed in a lab setting or in an actual patient environment

G-212

- Comp and eval & in-service: no evidence of checking competencies on extra skills; assistance with feeding, suprapubic cath care, hoyer lift tx
- Home Health Aide lacked documentation of extra skills (TED Hose)
- Some aide personnel records failed to show competency for assigned tasks prior to being assigned to do client care independently

G-214

- Agency failed to ensure the completion of a performance review of each home health aide no less than every 12 months
- Agency failed to show completion for performance evaluations of home health aides at least every 12 months
- Competency & in-service training: Performance evaluations exceeded federal guidelines (more than 1 year)

G-218

- Competency eval & in-service training: agency failed to ensure a RN performed direct observation of HHA performance of basic HHA skills on a pt or pseudo pt; Basic HHA competencies may not be demonstrated using a mannequin, or using verbalization or simulation; agency reported completing competency testing of bed bath, bedpan, and urinal by talking thru the procedures

G-322

- No parameters for policy; OASIS not transmitted
- Agency claimed "Best Practice" on OASIS for diabetic care, but had no physician orders to teach diabetic foot care

G-224

- Agency failed to provide individualized and specific written patient care instructions from a RN to agency home health aides. Care plan directed the hha to assist the patient during ambulation using an assistive device, but did not specify the assistive device to use. The hha care plan said to assist patient with skin care but did not specify what task completed by the aide was considered "skin care". Care plan for an Alzheimer's patient said per patient request but due to diagnosis client would be unable to direct cares.

G-225

- Agency failed to make sure all home health aides provided services according to the written assignment. Home health aide notes failed to document the reason the client was not shaved or weighed
- Assignment & duties of home health aide: no documentation of why aide did not complete task; lacked documentation aide the aide contacted RN for approval to assist the patient with dressing
- Aide did not complete assigned tasks per aide assignment; aide helped with shower not assigned and did not receive approval from supervisor
- Aide did not document as completed all tasks as assigned

G-226

- Agency failed to maintain patient clinical records with complete and accurate documentation and/or failed to correct errors per agency policy. Skilled visit note lacked and electronic signature. Corrections did not contain one line thru and initials for corrections. Skilled visit notes not locked timely according to policy.

G-229

- Agency failed to complete home health aide supervision. Patients did not have aide supervision by the 14th day
- Agency failed to supervise home health aides at least once every 14 days for 2 of 8 sampled patients.

G-230

- Supervision: SV visits no less freq than every 60 days for clients not receiving skilled care and aide must be present during SV; no direct supervision provided at recertification or at least every 60 days
- Missed Sup visits on aise; lacked documentation for patient cares RN observed aide completing missing aide visit note

G-236

- Clinical records: HHA obliterated entry, was not corrected properly per HHA policy
- Clinical Records: agency failed to maintain pt records with complete, accurate and timely documentation; failed to correct errors per agency policy; PT notes lacked a date of signature; OT note lacked date of signature; used abbreviation not on agency list; a communication noted no hha visit made per pt request however clinical record contained documentation of hha visit with personal cares provided; assignments on the HHA assignment sheet were not documented as completed and no documentation as to why not done; a SN visit note had electronic sig of completion exceeding agency policy by 18 days; SN visit notes contained inaccurate info re when physician dc'd wound vac; SN documented on "right foot wound" but client never had a "right foot wound", instead had a right ankle wound
- Aide documented tasks that she did not complete; missing medication records found in incorrect patient charts; no aide notes to match recertification and supervision of aide

G-303

- Discharge summary/review not provided to physician as per agency policy; did not notify physician of availability of discharge summary

G-321

- Agency failed to encode and transmit OASIS for each patient within 30 days of completing an OASIS data set
- Failed to transmit OASIS data timely

G-322

- Failure to transmit accurate OASIS data for adult patients.M2250a-the agency planned to place patient specific physician ordered vital sign and other clinical findings parameters for reporting of the POC, the patients clinical record lacked documentation indication the patients physician agreed to any patient specific parameters.M2250b- agency planned to place interventions related to patient's care plan r/t diabetic foot care, but record lacked documentation that the physician agreed. M2550C- Agency planned to place interventions r/t fall prevention interventions on POC, patients clinical record lacked documentation that the physician agreed
- Agency failed to transmit accurate OASIS data collected with each comprehensive assessment. M2250a- agency planned to follow its own parameter reporting guidelines for reporting vital signs and other clinical findings but the agency had no parameter guidelines
- Accuracy of encoded Oasis data: "best practices" indicated but HHA was not actually participating in it (multiple instances)
- Accuracy of encoded OASIS data: agency competed comprehensive SOC assess for Medicare/Medicaid pts but did not contain many of the OASIS data items; assessment on M2250 indicated that physician had no pt specific VS parameters and the agency would use standardized clinical guidelines on parameters for physician notification but had no guidelines for nurses to use as reference; assessment M2250b indicated that diabetic foot care on care plan but no order for diabetic foot care or monitoring; M2250c indicates that physician agreed with fall prevention on

POC but clinical record lacked documentation that physician agreed to fall prevention interventions
- Accurate OASIS data; no evidence of best practices but giving agency credit on M2250a; M1240, M2250b

G-330
- Agency failed to do a resumption of care assessment within 48 hours of referral or within 48 of return home.

G-332
- Agency failed to provide and initial assessment within 48 hours of referral or within 48 hours of return home and knowledge of return home
- Failed to complete initial assessment with 48 hours of orders

G-334
- Agency failed to ensure accurate completion of all pertinent components of the SOC assessment within the required time frame. SOC assessment dated 7/22 not locked until 7/29 exceeding the lock period by 2 days
- Agency failed to ensure accurate completion of all pertinent components of the start of care comprehensive assessment within the required time frames. SOC was not completed in the time frame required
- Staff failed to complete all pertinent components of care plan within 5 calendar day window, no vital signs parameters in place
- Admission OASIS not completed within 5 days

G-337 Comprehensive assessment must include review of all meds the patient is currently taking
- Drug regimen review: agency failed to include all over the counter and prescription drugs when completing drug regimen reviews; patient's resumption of care failed to include completed drug regimen review (x2); while in home, surveyor noted multiple medications that were not on the agency's medications list; patient told surveyor they were taking Tylenol, this was not on patient's medications list; patient reported taking Senna for 5 years for years, not on patient's med list; patient said had been taking ex-lax for years but was not on medications list
- Care plan lacked order for over-the-counter, hair, skin and nails supplement; care plan lacked eye drops that patient was administering
- DRR: POC lacked any orders for Naproxen and did include orders for meds client no longer taking; on home visit, pt bottle of med gave a different dose from what was on POC; since med lists incorrect, a complete DRR was not done

G-338
- Agency failed to ensure the accurate and thorough completion of a significant change in condition comprehensive assessment within 48 hours of an identified significant decline in condition

G-339
- Agency failed to ensure accurate and timely completion of all pertinent components of the ROC between days 56-60.
- Agency failed to ensure recertification visit was done between day 56-60
- Update of comprehensive assessment: OASIS not updated last 5 days of every 60 days
- Update of Comprehensive Assessment: Recert assessment done for new cert dated 7/14/16-9/11/16, visit made on 7/13/16 but not signed until 7/14/17 so exceeded requirement by 1 day; another recert visit done on 8/8/16 but not signed till 8/12/16 (new cert started 8/10/16 so

exceeded requirement by 3 days); recert assessments lacked documentation of wound assessment and measurements

- Recertifications not completed within last 5 days of episode

G-340

- Agency failed to complete resumption of care with 48 hours
- Resumption of care not completed within 48 hours of patient return home
- Incomplete resumption of care within 48 hours of patient return to home; no parameters; no pain assessment

G-341

- Agency failed to ensure accurate completion of pertinent components of the discharge comprehensive assessment with OASIS, electronic signature of completion exceeded agency policy by 4 days
- Patient transferred from agency to hospital gastronomy tube placement, transfer assessment was not completed until 3 days after the planned transfer
- Update of the Comprehensive Assessment: pt discharged on 8/26 but assessment not signed as completed until 8/29 making it 1 day late
- Untimely completion of transfer assessment within 48 hours of knowledge of transfer

G-342

- Staff failed to incorporate OASIS data items with each comprehensive assessment (separate documents)

484.12

- Compliance with Fed, State Local Laws: BG check indicated need for further research related to criminal research; no evidence that was done prior to hire

More on page 9: compliance tips

DME- cited on all surveys we looked at. Listing: hand held shower, orthotic shoes, automatic blood pressure cuffs, glucometers, insulin supplies, medi planner etc.

Drug Regime Review- Must do all 5 components at every oasis time point (G337)

1.) Duplications
2.) Ineffective Therapy
3.) Adverse Side Effects & Drug Interactions
4.) Significant Side Effects
5.) Non compliance

PRN medications—must have frequency, and reason why the client is using it. If cream or powder must specify where they are to be put on.

<u>Examples:</u>

Tylenol 1000mg po prn every 6 hours as needed for pain in shoulder. Not to exceed 4,000 mg in 24 hour period.

Nystatin powder 30g topical prn every 6 hours to reddened abdominal folds

Bisacodyl 5mg po prn every 8 hours for constipation

Wounds- need to follow company policy. Weekly wound measurement with all 3 things listed

1.) Length
2.) Width
3.) Depth—must address even if no depth

Chart Correction Policy- follow agency policy. Cannot cross completely out-auditors need to be able to read what was first charted. Do not write over the top.

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If you list vitals every visit then must list all vitals every visit:

1.) B/P
2.) Pulse
3.) Respiration
4.) Temperature
5.) Pulse OX- if your agency policy lists this as part of your vitals

SOC & Resumptions- Must have height and weight and if not done need a reason as to why not done

G322- Accuracy of encoded oasis data-

1.) M2250a- if you answer N/A- which identified the agency planned to follow its own parameter reporting guidelines for reporting vital signs and other clinical findings to physician—need policy of what those guidelines are.
2.) M2250b- Agency planned to place interventions related to assessing and teaching diabetic foot care on the patient's POC. This indicated the agency planned to participate in a "best practice". The patient's clinical record lacked documentation indicating the patient's physician agreed to placing this on the POC.
3.) M2250c- agency planned to place interventions related to fall prevention on patient's POC. This indicates the agency plans to participate in a "best practice". The patient's clinical record lacked documentation indicating the patient's physician agreed to fall preventions on the POC.
4.) M2250d- Agency planned to place intervention related to depression interventions on POC. The record lacked documentation to physician.

Medications M2001- if clinician checks yes- they identified a potential clinically significant medication issue and then at next question M2003 the clinician checks yes- they did contact a physician (or physician designee) by midnight of the next calendar day and complete prescribed/recommended actions—need documentation in the chart of physician clarification of the medication