Iowa Health Care Association
HHA Survey Review G-Tags
September 2015

The five most frequently cited tags from the 13 recertification surveys (1 deficiency free), 2 complaints [one of which was conducted with a recertification survey] (0 unsubstantiated), 2 revisits (1 with no deficiencies), recently reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 106 total deficiencies. **There were no condition level deficiencies and no partial extended or extended surveys.**

Total # of reports: 16
Total # of surveys deficiency free or unsubstantiated complaints: 2
Average # of deficiencies (all)

- **All = 6.6**
- **Recertification =8.4**
- **Complaints=6.5**
- **Revisits=1.5**

G-236 (42 CFR § 484.48 **A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services.**

In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. . .)

1. Failed to maintain patient clinical records with legible, clean and accurate information, filed in timely manner and did not follow policy when correcting errors; Did not follow policy of finishing documentation in 24 hours; Corrections were written over and obliterated.
2. Agency failed to maintain readable, complete and accurate records; Did not follow policy in how to correct errors.
3. Clinical records; failed to maintain current and complete records; making clinical corrections by drawing line through and writing "void."; Lacked physician orders for skilled visit.
4. 1. Failure to date signatures; software puts in signature but not dated. (no electronic "time stamp").

   2. Missed SNV in paper file, but pulled off electronically.
5. Failed to file records or make corrections per policy as evidenced by (hereinafter "AEB")

   1. INR ordered 1/27, done on 1/28 but not documented on HV. INR ordered on 2/23, done on 2/24; verbal order from Doctor :"Ok to draw PT scheduled on **3**/24 with SNV on 2/24."

   2. Ns documents visit on Wednesday, 1/20/15, but 1/20 was on Tuesday. Ns inaccurately recorded date as 1/20 instead of 1/21 (there was a holiday that week).

   3. Resumption of care weight 3/10/15 "150" but 3/12/15 weight "191" and 3/19/15 weight "196".

4. Double line cross through instead of single line cross through without dates or initials for SOC date 4/17 vs 4/19 correction.

5. Writing over BP “81” vs “91” so couldn’t tell correct reading;

6. Orders for QID SNV but 1 day with 3 SNV and 1 day with 2 SNV without document of why, but found in filing (they were made).

6. Clinical records: staff did not turn documentation in to office in a timely manner; did not correct documentation per agency policy; POC lacked orders for size of foley catheter or orders for changing the catheter.

7. Failure to maintain timely, complete, accurate clinical records AEB

1. Agency Director admits <u>NO</u> timeframe in policy for completing documentation but would like it to be done within 48 hours.

a. 4/5 visit electronically completed on 4/26/15.
b. 4/6 visit electronically completed on 4/24/15.
c. 4/8 visit electronically completed on 4/22/15.
d. 4/10 visit electronically completed on 4/27/15.
e. 4/13 visit electronically completed on 4/23/15.
f. 4/14/15 visit electronically completed on 4/27/15.
g. 4/15/15 visit electronically completed on 5/3/15.
h. 4/16/15 visit electronically completed on 5/3/15.
i. 4/17/15 visit electronically completed on 5/3/15.
j. 4/20/15 visit electronically completed on 5/3/15.
k. 4/22/15 visit electronically completed on 5/3/15.
l. 4/24/15 visit electronically completed on 5/3/15.
m. 4/27/15 visit electronically completed on5/3/15.
n. 4/29/15 visit electronically completed on 5/3/15.
o. 5/4/15 visit electronically completed on 5/18/15.
p. 5/6/15 visit electronically completed on 5/18/15.
q. 5/11/15 visit electronically completed on 5/18/15.
r. 5/13/15 visit electronically completed on 5/18/15.
s. 5/4/15 visit electronically completed on 5/8/15.
t. 5/7/15 visit electronically completed on 5/14/15.
u. 5/12/15 visit electronically completed on 5/15/15.

8. Clinical records – Did not follow agency correction policy. Not filing visit notes within 7 days as agency policy dictated.

9. Did not follow agency correction policy. Not filing visit notes within 7 days as agency policy stated.

10. 1. Agency Director admits <u>NO</u> timeframe in policy for completing documentation but would like it to be done within 48 hours.

a. 1/14 SNV signed on 1/18;
b. 1/27 SNV signed on 1/30;
c. 3/5 SNV signed on 3/9;
d. 2/27 MSW visit signed on 3/6
e. 3/4 SNV signed on 3/9;
f. 3/6 SNV signed on 3/12;
g. 3/9 SNV signed on 3/14;
h. 3/11 SNV signed on 3/15;

i. 2/27 MSW visit signed on 3/6;

j. SNV documented pt. respiratory rate of 200; **Staff said "sometimes the computer fills in numbers!"**

k. SNV documented pt. respiratory rate of 220

l. no "/" mark in between BP so BP read 12668 instead of 126/68;

m. SNV documented pt. Temperature as 998.5

n. Order for PT eval. obtained, but never done; no evidence of why no done;

o. Record documents SOC as 12/13/**16**; Dr. order to hold visit until 12/16/13, which HHA said it did;

p. Diabetic pt. with black eschar on heel, but some visits document skin intact while visit on adjacent days document eschar; no measurement of eschar;

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

1. Agency failed to obtain current physician order for wound care prior to initiating treatment.
2. Plan of care failed to obtain patient care orders signed by MD, DO, or doctor of podiatry. Interim order signed by physician assistant.
3. Agency failed to ensure services occurred within physician orders; no orders for wound care provided; order to call for B/P out of parameters – no evidence of call; Did not note pain on scale of 0-10 as written.
4. Failure to follow physician orders – verbal order lacked physician date.
5. Failure to follow physician orders – documentation lacked treatment order to left breast.
6. Failure to obtain orders from doctor (ARNP can't authorize service) Admission by HHA orders "we just took the POC to doctor and he signed them as he had approved of patients' care all along."
7. No order to continue certification and no interim order received either. Orders signed by ARNP.
8. 1. Failure to follow doctor's orders AEB SNV 1x/wk but no visit 4/19-4/25 – no documentation of why omitted; doctor notify, etc

   2. SNV/3X/wk – msg visit without physician notification.
9. 1. Orders for SNV 2wk1X1, then 1wk1x8; 1 week without SNV and no missed visit report to physician (HHA explained "new nurse")

   2. orders for weekly SNV with orders to draw PT/INR; no INR/PT 3 weeks in a row and no evidence Dr. was made aware of this;

   3. orders to increase visits to QDX1 week; but only one visit documented and no missed visit notes sent to doctor;

   4. orders for SNV 1X/wk; but two weeks in a row there were 3 X/week visits; **(legal commentary: if those visits are billed prior to a signed physician's order being received, this would be a false claim and the money received would need to be repaid to the payor)**

G-159 (42 CFR § 484.18(a) **The plan of care developed in consultation with agency staff covers all pertinent diagnoses, including mental status, types of services and**

equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.)

1. Agency failed to ensure accurate completion of all components of POC and contained current information; POC did not have dosage of medication; Lack of order for wound care; Medications lacked specific frequency.
2. Agency failed to ensure complete and accurate orders for one POC. POC did not report ALL equipment used by the client (stool riser, grab bars, Ted hose, ½ bed rail, Life line, incontinent briefs); medications lacked frequency and where to apply medication.
3. Agency failed to ensure POCs were current and accurate; Medications did not have frequency. NO reason why client took OTC medication; catheter prn order did not identify "reason" it would need change and did not include specific catheter size; order states 1 prn skilled nurse visit but no reason why.
4. POC care lacked equipment orders used by patient. (Shower chair, shower bench, wheelchair, medication boxes, chair lift); PRN medication lacked reason for taking medication; omission of the following DME used by patient: glucometer, gauze wrap, tape, gloves.
5. Failed to make sure POC contained current and accurate information; not All DME listed; Medication did not identify strength.
6. 1. "incomplete orders"; orders for TAO, ZnO2, A&D, and chap stick without documentation of where to apply and frequency; ear drops to "affected ear" failed to identify left or right.
   2. ARNP provided orders for sliding scale insulin 9/18, then agency transcribed on to order sheet for doctor to sign, but sliding scale insulin not incorporated into 3 subsequent POCs (6 mo)
7. Plan of care – PRN medication with no reason of why client takes the medication; Did not include All DME equipment in the home.
8. Failure to provide care per doctor's orders AEB:
   1. Diabetic with diagnosis of open foot wound, complicated IDDM, and cellulitis, but goals on POC failed to address open wounds;
   2. Wound vacuum orders failed to identify frequency and what material to use on wound;
   3. SOC OASIS says O2 at 2l/nc but not included in POC orders under medications (no O2 orders, no delivery method, e.g., cannula, mask, etc.)

G-224 (42 CFR § 48436(c)(1). . . **Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.)**

1. Assignment of duties of HHAide: Aide care plan was not individualized for client; skin care failed to specify what type of skin care;
2. Agency failed to provide individualized and specific written patient care instructions for home health aide; Home health aide care plans not specific to meet patient's needs on shampooing, lotion application and foot care.

3. Agency failed to provide individualized and specific written patient care instructions. Care plan identified “shower or sponge bath”; Did not tell HHAide when to give which one.
4. Assignment and Duties of HHAide: Care plan stated provide skin care – failed to provide individualized specific directions.
5. Skin care – not individualized and specific
6. Failure to provide specific home health aide directions AEB
    1. “Assist with shower/sponge bath, either/or” but didn’t identify when to use which. (Patient with Orthostatic Hypotension (OH) so shower could be an issue)
    2. Same as above except the OH factor.
    3. Same as above except the OH factor.
    4. Same as above except the OH factor.

7. Home health aide sheet directed home health aide to bathe patient in tub or bathe patient by giving sponge bath but did not direct home health aide when to do which one; Lacked individualized direction of applying braces.

G-339 (42 CFR § 484.55(d)(1) . . . **[updating of the OASIS is required not less frequently than . . . .] The last 5 days of every 60 days beginning with the start of care date, unless there is a (i) Beneficiary elected transfer**
(ii) Significant change in condition; or
(iii) Discharge and return to the same HHA during the 60 day episode.)

1. Recertification Assessment not accurately filled out. Blanks left for height/weight/radial pulse.
2. Agency failed to assure timely completion of recertification comprehensive assessment: Recertification assessment lacked documentation of diabetic status; Fall assessment coded “0” for drop in B/P but no orthostatic B/P checked; Not locked in timely manner.
3. Update to comprehensive assessment: Pediatric assessment failed to direct staff to assess fontanelles.
4. Update of comprehensive assessment: Assessments not completed within guidelines of proper timeframes.
5. Comprehensive Recertification OASIS not completed accurately or fully AEB:
    1. No radial pulse, height, weight, BP, cardiopulmonary assessment; DIA claims can’t use Wong-Baker pain tool faces because of patient’s severe intellectual disabilities;
    2. Same as #1
    3. Same as #1 and no pedal pulses, safety measure, environmental hazards, nutritional assessment
    4. wt/ BP missing
    5. Radial pulse/BP missing
    6. Weight/reproductive assessment missing
    7. Height/weight/radial pulse missing
    8. Apical pulse; pedal pulse, BP, reproductive assessment missing
    9. Apical Pulse missing
    10. Apical Pulse and pedal pulse missing
    11. Order for weekly weight but weight not documented in OASIS

12. Missing document of reproductive system and neurological/emotional/behavioral status

6. Update of comprehensive assessment–Recertification assessment: Not completely filled out related to height and weight; not signed within window

7. Update of comprehensive assessment–Recertification assessment: Not completely filled out: height and weight were blank;

G-172 (42 CFR § 484.30(a). . . . **[The registered nurse. . .] regularly re-evaluates the patient's nursing needs, . . .)**

1. Agency nurse failed to adequately re-evaluate patient status and response to care; skilled visit note lacked documentation of diabetic status with primary diagnosis of diabetes; no B/P checks; Did not take vitals in 2 week old baby; assessed patient's feet/ankles without taking socks off; Did not assess skin of patient with buttock breakdown. No measurements of wounds.

2. RN regularly re-evaluates patient's nursing needs: Lacked documentation of wound measurements.

3. Agency failed to ensure agency nurses adequately re-evaluated patient status; wound had no depth charted; Lacked physician notification of B/P out of range of parameters.

4. Failure to re-assess patient status AEB:

    1. Order to monitor pulse ox – report under 90% ; no pulse ox documented

    2. 3/4/15 buttock would superficial 2.5 cm x 1.5 cm – Stg. 2 without drainage; 1 week later, nurse asks if patient needs help apply Desitin to "gluteal dry skin areas" – didn't measure [3/24 Surveyor HV: no open area; record didn't say when healed – Nurse speculates healed sometime between November and January; later tells surveyor healed about 3/10; **Legal recommendation: Do not speculate; it destroys your credibility**].

    3. Patient with OH and history of falls with injury; failure to check orthostatic BP by NS, PT; sitting B/P 88/54; sitting BP 88/57; sitting BP 104/48; sitting BP 90/60.

    4. Same as #1 but different patient.

5. Failure to re-evaluate status on wounds AEB:

    1. Wound Vac orders didn't say where to apply or how frequently to change dressing.

    2. Measurement of wound length and width, but no depth X 11 visits;.

    3. "Superficial coccyx" wound had length and width measurements but no depth;

6. Duties of RN: No wound measurements;

7. Failure to re-evaluate nursing care needs AEB

    a. 2/4/15 NN says R. ankle lesion .3x.3x.1; but on Comprehensive Recertification on 2/5/15 nothing is said about the ankle;

    b. **Surveyor visit with LPN to home of diabetic patient: patient with approximately 3.8 cm X 3.8 cm X 0 cm black eschar; NO MEASUREMENTS TAKEN;** visit 8 days prior identified the area as a "blood blister "half dollar" in size (without measurements taken); and there were daily SNV without documentation of the wound;

    c. Pt. with L. knee wound infection and orders to increase visits to 2X/wk for wound care; 4 visits in 10 days without evidence of measuring the wounds or providing wound care;