Iowa Center for Home Care
HHA Survey Review G-Tags
3rd quarter 2016 (June, July, August)

The five most frequently cited tags from the 7 recertification surveys (1 deficiency free), 2 extended (0 deficiency free), 1 complaint (1 deficiency free), 3 revisits (1 deficiency free) recently reviewed by the ICHC Survey Results Committee are listed below with narrative. There were 100 total deficiencies. There were no condition level deficiencies and no partial extended. There were 2 Inability to Competize insufficiencies.

Total # of reports: 13
Total # of surveys deficiency free or complaints unsubstantiated: 3
Average # of deficiencies

- **All = 7.7**
- **Recertification =4.2**
- **Inability to competize=5.5**
- **Complaints=0**
- **Revisits=3.7**

G-236 Maintain clinical records in accordance with professional standards

- Documentation not consistently completed within 48 hours as required by agency policy.
- Agency failed to timely complete an accurate clinical record; agency visit notes signed after 48 hours in violation of agency policy; RN signature signed electronically, late according to agency policy; clinical record lacked DK summary; staff did not follow agency correction policy.
- Incomplete clinical records—plan of care included skilled nursing visits Feb. 18 through April 17 but not recorded they were begun until March 11; clinical supervisor was to call patient regarding satisfaction with services, no documentation this was done; plan of care lacked direction for staff to use a slide board when transporting patient from wheelchair to bed; nurse aide care plan stated resident indepedent transfer, plans didn't match; patient refused physical therapy, this was not documented; patient discharged by physician, nursed failed to complete discharge assessment.
- Timely filing, not following policy, how fast things are filed, verbal order received during skilled nursing visit but no signed order and not listed on plan of care; start of care plan plan of care not signed and next plan of care not sent for signature; same medications list used twice with different orders, nurse reported one should have been removed; signatures missing on entries; documentation misfiled in wrong client chart; error corrections not completed per policy.
- Clinical notes not signed in a timely manner; medications list not complete nor accurate.
- Agency did not follow policy for correcting errors in documentation; "error" not written on correction.
- Wound sheet did not match visit note; skilled nursing visit notes signed later per agency policy; plan of care lack listing of DME in the house.

G-159 Acceptance of patients, plan of care & medical supervision, plan of care covers all pertinent diagnosis

- PRN meds did not specify reason for use; no discharge plan on plan of care; home health aide services provided with skilled nursing services; not all DME used in the home was listed on plan of care.

- Durable medical equipment: scale, mediplanner, shower chair, Depends not listed but were used; grab bars listed but not applicable to current residence, patient had moved the previous summer but plan of care not updated to reflect changes in equipment.
- Plan of care did not identify when and under what circumstances a client would be discharged "client will care for self on discharge."
- Agency failed to ensure physician-ordered plan of care contained accurate, complete and up-to-date information, order lacked reason for PRN medication; order lacked area of the body to apply cream; DME not listed on plan of care that client had in their home.
- Medication orders not complete regarding administration of eye drops; no order specification for why patient needs a PRN nurse visit.
- Orders for discontinuation of oxygen not transcribed to subsequent plans of care; no plan for following physician's orders to place patient in stander following tube feeding when patient weight exceeded lifting limits for one staff transfer; patient needed increased HVIs and nursing hours but agency could not meet needs from Sept. 5, to Jan. 1, failed to follow physician's orders.

G-158 Care follows written plan/reviewed by physician

- No physician's orders to continue PT & OT services into next certification period; no orders noted to continue services into the next certification period; no physician consent signature on ARNP orders for wound care; no order to decrease health visits from twice to once weekly; SNF visit made after start of recertification with appropriate physician's signature; wound care provided by nurse did not match physician's order.
- Agency failed to provide services according to physician's orders and failed to notify physicians of a change in condition; did not notify physician of missed home health aide visits, and waited more than three days to start the home health services due to hot weather conditions (staff would not enter hot house).
- Plans of care showed missed home health aide visits that were not reported to physician; wound care not carried out; orders signed by physician eight days after the agency resumed patient's care.
- Start of care Oct. 28, 2014, plan of care Dec. 22, 2015 to Feb. 19, 2016, includes orders for skilled nurse visits one to two times per week with oxygen saturation recording each visit, documentation lacked for the Jan. 13, 2016 visit; patient on antibiotics for current infection and nurse did not take temperature, which was ordered, "vital signs when indicated;" patient on anti-biotic for non-healing wound with orders for nurse to obtain vital signs and instructions to patient to take own temperature and pulse readings; no nurse documentation of temperature on one visit and no vital signs documentation on another visit.
- Agency failed to notify physician of the results of therapy evaluations.

G-337 Comprehensive assessment must include review of all meds the patient is currently taking

- Drug regimen review not conducted appropriately; plan of care contained orders for previously-discontinued medication.
- Drug regimen review—facility failed to ensure drug regimen review for nine of twelve sampled patients requiring drug regimen review after the agency's resumption of services per agency's policy.
- Facility failed to conduct a drug regimen review with two discharges; the second patient discharged was "telephone call discharged" with not visit or assessment documentation.
- Drug regimen review failed to include potential drug interactions (i.e. two medications for high blood sugar, two for high blood pressure); order for Tylenol (patient never takes Tylenol); PRN aspirin order, self-reported by patient during home visit: review failed to list hypotension as potential side effect of medications, client reported dizziness during home visit (a sign of hypotension); review failed to list hypoglycemia but patient should signs of it during visit; review

failed to list hypotension—documentation showed client was hospitalized for hypotension; review identified ineffective drug therapies but did not identify which were ineffective.
- Drug regimen review not conducted during initial assessment.
- Agency failed to complete an accurate drug regimen review.

G-176 Regularly re-evaluates patients' nursing needs

- HHA assignment did not include application of physician-ordered application of medicated creams.
- Agency failed to ensure RNs coordinated with physicians and/or home health aide did not notify physician of patient's weight loss; did not notify physician of missed home health visits; nurse failed to coordinate therapy visits and contact therapy company.
- Home health aide routinely helped patient apply compression socks and Nystatin powder; nurse aide visit notes lacked documentation this was done; RN failed to identify discrepancy; notes lacked that home health aide helped the patient with the exercise program and range of motion exercises; the notation "exercise not required during visit" didn't jibe with the RN's order.
- Aide assignment sheets lacked specific individualized direction.
- RN failed to coordinate services for family, physician and therapy.