Iowa Center for Home Care
HHA Survey Review G-Tags
3rd Quarter 2018

Total # of reports: 14

Average # of deficiencies

All = 4.71
Recertification = 6
Complaints = 2
Validation survey = 0
Inability to competize = 6
Revisits = 6

Survey Summary and be sure to see Compliance Tips at the end

G-Tags cited by Iowa Department of Inspections and Appeals

Old CMS description of G-tags

New G tags

G-372

- Encoding and Transmitting of OASIS: Agency failed to transmit OASIS data within 30 days of the OASIS M0090 date.

Example: Agency did not have record of Final Validation report to show record of OASIS transmission. OASIS data was finally resubmitted, but doing so was completed after 30 days of M0090 date

G-410

G-478

- Failed to investigate complaints. During home visit, patient verbalized complaint re: lack of responsiveness to concerns and therapy was not intiated in a timely manner. Found therapy was initiated over 10 days after SOC. RN did not report concern to Adm, and two days later DIA reviewed complaint log and no investigation was made.

G-484

- Failed to document complaints. As above.

G-514

- Failure to provide an initial assessment visit within 48 hrs. The agency did not document the reason for delay of the initial visit and there was no physician order delaying the initial visit

Eight patients did not have a timely initial assessment visit. The initial visit/SOC was 3+ days after referral, without any documentation why there was a delay, or any documented physician ordered SOC date.

G-528

- agency failed to include an individualized assessment relating to the current health status when completing comprehensive assessments.Documentations lacked measurements of length and width of wound and lacked patient blood sugar reading.

G-536

- Failure to complete a drug regiment review, including all required components, with each comprehensive assessment with the allowed time frames and/or failed to identify medication discrepancies at the time of the comprehensive assessment.

Example 1: Clinician documented DRR was done at each comprensive assessement, but there were duplication of pain medications on med list, yet the clinician documented in DRR that there were no concerns.

- 5 of 17 patients did not have a complete or accurate DRR. All of these were found during home visits, where it was noted that the patient advised they either were or were not taking specific meds, mostly topical or eye drops, OTC, etc-- which didn't match up with the DRR by agency. Included was Nystatin, aspercreme, ibuprofen, Deep Blue rub, Refresh eye drops. There were also Rx which were found to have different doses, confirmed by RN to be incorrect after talking to pharmacy.
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Example 2: Clinician failed to perform Resumption of Care and DRR after a more than 24 hour inpatient stay

- Failure to ensure medications reviewed at the time of each DRR are current and accurate. ROC lacked DRR; POC had meds that were not currently being used; POC lacked an order for a vitamin supplement; POC lacked an order for eye drops; POC lacked an order for inhaler

G-542

- Incorporate OASIS items: Agency failed to assure that the SOC, ROC, recert and DC comp assessment with OASIS included an integration of the OASIS data set into the agnecy's own comprehensive assessment in a clinically meaningful manner making the document an integrated comprehensive assessment. Agency policy was that all adult patients in the agency's disease and disability and bath program receive a comprehensive assessment with OASIS data upon dishcarge. In reviewing charts, OASIS assessment items were missing on the numerous assessments; Electronic clinical records included a skilled nurse visit report (which included wom IASIS data items) and a separate OASIS data report containing the rest of the requried OASIS data items, for each comprehensive assessment. These reports were not signed and dated at the same times.
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G-546

- Agency failed to ensure accurate completion fo all required components of the recertifications. Recert oasis was not locked by day 60.
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- Agency failed to ensure accurate completion of all required components of the recert comprehensive assessments between day 56 and 60 of ea 60 day cert period. Recerts initiated during day 56-60 but not completed with all required info by day 60. .

G-548

- Failure to ensure accurate completion of all pertient components of the resumption of care comprehensive assessments within 48 hours of the agencys knowledge of return to home from an inpatient facility.
- agency failed to ensure accurate completion of all pertinent components of the resumption of care comprehensive assessment within 48 hours of the agencies knowledge.

- Clinican aware of patients scheduled trach surgery. Patient admitted 3/20 at 6:53am and discharged on 3/21 at 11:00am. Clinician didn't realized that the patients admission exceeded 24 hours so resumption wasn't done.

- Agency failed to accurately and thoroughly complete ROC comp assessments in a timely manner (within 48 hrs of patient's return home froma a hospital admission of 24 hours or more). One completed a recert assessment instead of a ROC; one was completed 8 days after knowledge of discharge; transfer assessment was also one day late.

- Resumption of care not timely (w/in 48 hrs) No identification of resumption referral date

G-550

- agency failed to ensure completion of a discharge comprehensive assessment within 2 days of the agencies knowledge of the need for discharge.
- Failure to accurately and thoroughly complete discharge comprehensive assessments in a timely manner: DC comp assessment initiated on time but not completed for 8 days; DC occurred 1/3/18 and comp DC assessment was initiated and completed 14 days after the discharge
- DISCHARGE: Agency failed to ensure accurate completion of D/C comprehensive assessment within 2 calendar days of identification of need to D/C patient. Agency documented a transfer comprehensive assessment for pt. to go to inpatient facility, when patient actually was admitted to another home health agency.
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G-570

- agency failed to ensure skilled professionals provided care as ordered by the physician, failed to complete individualized POC, failed to ensure skilled staff recorded all verbal orders, failed to promptly alert the physician to changes that may suggest a need to alter the POC.
- the agency failed to ensure skilled professionals provided care as ordered by the physician, failed to ensure agency skilled staff integrated servies to assure identification of patient needs and factors that could affect patient safety and treatment effectiveness by all disciplines.

G-572

- agency failed to notify the physician of changes in visit frequency ordered on the POC. Clients chart lacked evidence of skilled visit notes. Agency notified physician of not able to do client visit early in the week but did not attempt to find client for the rest of the week. Charts lacked documentation of monitoring of blood sugars as ordered.
- agency failed to follow physician orders as indicated on the careplan in a way to meet the needs of a patient. Patients urinary catheter was removed and patient did not have an output on own after 8 hours and called nurse to put catheter back in and on-call nurse did to arrive until 12 hours after the catheter was removed. Orders for a wound on foot no followed per physician orders.Agency told patient they could not do a weekend visit as medicare would not cover it and

the patient could be liable for 150.00 so pt requested a discharge and now the wound has worsened, The agency did not coordinate the patients care adequately to meet the patients needs.

G-574

- Failure to maintain complete and accurate Plans of Care w/ current orders: DME, Medications/treatments.

Example 1: Surveyor observed at home visit lack of DME on the POC that was in the client home and that the client was using
notes by 2 different therapists have differing documentation of patient ambulation (one said independent; one said with chair lift on their therapy evaluations. Pulse oximeter and stair chair lift not on POC for patient. Missing shower chairs, etc.

Example 2: Physician Order written for medication, lacked the name of the medication and dosage

Example 3: Physician Order written for pain patch, lacked the dosage and where the patch should be applied

- agency failed to ensure completion of all components comprising the POC. Pts. POC lacked DME products found in the home, toilet seat riser, grab bars, reachers, cryotherapy.
- Failure to maintain complete and accurate POC; POC failed to include DME such as incontinence supplies, toilet riser with handles, and left hand splint (identified by OT), and quad cane. Eyedrop listed on med list and POC did not specify whether eye drop was for one or both eyes.
- Multiple PRN medications did not specify reason for medications. Multiple patients were found upon home visits to have "DME". These included "reachers, thera bands, bedside tray, briefs, glucometerand hand weights for exercise".

G-576

- agency failed to update POC with all new physician orders. Patient medication verbal order did not show in the clinical record.

G-580

- Failure to administer medication only as ordered by the physician.

Example 1: Surveyor home visit: POC stated RN to set up mediations weekly from locked med planner. Surveyor observed that on this day, client still had 8 days of twice daily medications remaining.

Example 2: POC ordered Calcium 600 mg/Vitamin D3 200 iu twice daily. The bottle in client's home read Calcium 600mg/Vitamin D3 800iu.

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G-590

- agency failed to report changes in patient clinical findings to the physician as directed by the POC. Blood sugars exceeded number that needed called to physician. Staff failed to call blood sugars out of range.

G-606

- agency failed to coordinate care provided by all disciplines and integrate services to assure patient needs are being met.Clients medical record did not have hard notes from PT/OT. Clinical documentation did not show that the RN's reviewed the therapy notes.

- Agency failed to coordinate care provided by all disciplines and intergrate services to assure pt. needs are being met.The patient's clinical record included a physician order dated prior to admit date, approving blood draws performed by the agency LPN. Three additional physician orders were found with dates prior to admit date. Skilled nursing visit notes were found in clinical record with three dates prior to admit.

- The Home Heatlh Aide reported watching the LPN let the patient attempt to draw his/her own blood "many times" (reported patient used a butterfly needle) and had conflicting reports on whether or not a report of this had been made and whether or not the incidents were ever followed up on. LPN did not report non-compliance of patient related to the blood draws to an RN.
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G-608

- failure to effectively coordinate care.Care was not effectively coordinated to prevent urinary retention and abdominal distention following the removal of a urinary catheter. Patient with wound care did not have care coordinated to adequately meet their needs.

G-622

- agency clinical manager name phone and/or email not included in the agency admission packet given to patients.

G-684

- Infection control policy was not followed. Entered bag without cleansing of hands. Put equipment back into bag without cleansing equipment. Picked up meds /cups that fell to floor, and then began setting up meds again (using bare hands that had not been re-sanitized) without sanitizing.

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G-700

- Coordination of care with skilled professionals not completed

G-706

- Failure to assess wounds, including measurements, each wound at leaset weekly as identified by agency policy.

Example: Clinicians notes not reflecting compliance with agency policy in weekly wound measurments lack of wound measurements length, width, depth. Lack of reassement of wounds, complaint by patient via facebook in patient chart but no internal investigation done by agency and no documentation of resolution with patient. Did not use agency formal policy for complaints. Patient was d/c and admitted to hospital for possible sepsis-patient went to emergency room on own.

G-710

- Failure to provide care in accordance with the physician ordered POC; a ST eval lacked assessment info and was not electronically signed as completed; Agency had a policy that therapy evals would be done within 7 days of referral being made to therapy; PT eval was done on day 8; OT eval was delayed and no physician order to delay or discontinue the eval. SN set up med box with 2 talbs of Vitamin D 2000 units (total of 4000 units) but order was for just 2000 units
- Agency failed to ensure skilled professionals provided care as ordered by the physician in the POC: Agency policy for client currently undergoing wound treatment is for weekly assessment and documentation of wound including measurements….order for 3 SNV during the week and visits were made but no measurements weree obtained by the nurse during the entire week; documentation of Stage 1 pressure ulcer measuring 1 cm by 1 cm by "superficial in depth" (if wound had a depth that was superficial, the stage of teh pressure ulcer would be 2) orders were for 1w2/1 q other wk thereafter and to measure wound weekly...this was not completed/documented
- failure to provide care on POC: vital signs, cardiac assessment, respitory assessment or a gastrointential assessment. Pulse ox
- 5/17 patients reviewed did not have their additional therapy services, in multidisciplinary cases, initiated in a timely manner. The agency policy was seven days. Therapies were not always initiated within this timeframe, and no documented reason/communication with Dr regarding delay.

G-718

- Failure to report changes and coordinate care with physician. Wound changes and additonal wounds and other signs and symptoms of possible infection unreported to physician. No evidence of aides visit as requested on POC.
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G-768

- Aides not competency tested in all areas of baths, and shampoos. Clinical manager reported had oly verbalized HOW to perform oral hygiene, urinal, bedpan and ambulation in the agency office. Competentcy test results did not evidence that RN had evaluated the answers and determined aides competency.

G-772

- No evidence of documentation of compentencies (extra skills) whether documented in a laboratory setting using a pseudo patient or in a home setting while being performed on actual patient.

G-800

- Agency failed to ensure that aide services are provided only as ordered by the physician. The aide did not follow the RN direction when providing care to patient. Aides did not document reasons for omission of the following: showering, applying lotion, sponge bathing, combing hair, peri care, dressing, etc.

G-804

- Agency failed to ensure that home health aides coordinated and reported concerns to the RN.Improper notification/conflicting reports of when admin. staff were notified of patient injury. Involved aide's timesheet includes additional time that is not backed up with documented cares in patient's home. Several additional incidents documented where the aide reported changes in patient condition and the RN did not follow up with the patient in a timely manner or did not follow up at all.

G-808

- supervisory visits not completed on aides

G-940

- Organization and Administration of Services: Agency failed to furnish at least one service only by direct employees, instead contracting skilled nursing and therapy.

Example: Staff list given to Surveyor had only RNs and Therapys listed as contracted staff none were directly employed by the agency.
Appears agency had an unauthorized branch. Was performing business out of another site- which had a phone, fax, etc. Upon survey, the parent office stated their census, citing the home office census vs this "additional site" census. This was closed due to citation.

G-942

- Governing Board cited due to lack of oversight resulting in this unauthorized branch.

G-948

- Agency staff falsified documentation of 5 sampled patients - this identifiedthat agency staff were not ofllowing agency policy for reporting patient concerns or changes in condition. The Administrator left the state prior to the survey and did not identify the above stated concerns, prior to leaving on vacation.

G-970

- Parent branch relationship- Again, unauthorized branch was being maintained.

G-1008

- Failure to ensure agency staff documented accurately without falsification. Patient reported that the LPN could not get any reading on a pulse ox machine, so patient watched the LPN "Just write something down on the paper." Documentation states that the pulse ox reading was "94%". The LPN that was watching the patient draw his/her own blood, told the aide to go ahead and document that she had completed a bath with the patient, even though she had not done so. The aide did document the completed bath, because the RN told her to. Also noted the home health aides had falsified their tiimesheets, with no patient documentation to justify their reported times of patient care.

G-1022

- Failure to complete and send transfer summary to either the primary care physician or physician and other health care professionals responsible for providing care to the patient where the patient was transferred.

Example: Patient hard and electronic chart lacked evidence of transfer summary being sent to pcp and to hosptial where transferred.

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G-1024

- Authentication: Agency failed to authenticate all entries in the clinical record with a clinicians signature with date and time of the signature.

Example 1: Recert OASIS being done 1:02-1:34pm, but assessment was signed as completed by RN at 1:00pm 2 min before RN's arrival

Example 2: SRC OASIS done from 2:15-3:21pm but assessment was signed as completed by RN at 2:30pm (15 min after arriving, and then 51 more minutes of assessment being done)

Example 3: Lack of time authentication on several RN assessments

E-017

- Emergency plan not in patient clinical record/comp assessment. Emergency plan in patient home folder did not have any "hand written entries". But was just pre-printed with what to do if no electricity, weather, etc.

E-024

- Emergency prepardness pland and related policies: Agency failed to identify the process and role volunteers would have in an emergent situation.

- Agency had corrected all previously cited deficient practices and back in compliance.
- No policies and procedures for use of volunteers in an emergency or other emergency staffing strategies during an emergency

E-023

- Emergency Prepardness plan and related policies: Agency failed to identify the process for protections of patient documentation and process to keep the information from unauthorized access should an emergent situation occur.

E-037

- Emergency Prepardness Training: failure to document training to all individuals providing services, including directly hired employees and those under arrangement
- Agency failed to ensure training in emergency prepardness to all individuals providing services under arrangement.
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- Emergency preparedness training for all staff (including contract or services under arrangement not evidence.
- Emergency preparedness training was not fully done nor documented. Focused on lack of training for EP by contracted therapy staff.