HHA Survey Trends Report

August 2025

A LeadingAge Iowa Publication to help Home Health Agencies track deficiency data from the Iowa Department of Inspections, Appeals and Licensing and utilize the information for performance improvement.

Website:

www.LeadingAgeIowa.org

Tel: (515) 440-4630

11001 Aurora Avenue

Urbandale IA, 50322

August Home Health Agency Survey Report

by Kellie Van Ree, Director of Clinical Services

There are currently 130 certified home health agencies in the state and 50 of those are accredited agencies. Of the remaining 80 home health agencies, none have exceeded the 36 month recertification period.

In August, DIAL reported that they completed 3 complaint/incident investigations and 2 recertification visits. However, there was only 1 recertification report and 2 complaint reports available for review.

Of the 2 complaint reports, only one agency received a deficiency. The recertification visit resulted in 7 deficiencies. These deficient practices are outlined below.

Deficiencies Cited in August

E0037 – All staff were not trained on the emergency preparedness plan as required.

G0418 – Patient #7 did not receive an explanation of their rights and responsibilities until 6 days after the start of care.

G0440 – Patient #7 did not sign a consent for treatment including what disciplines were anticipated to be involved in care and service during their episode of care until 6 days after the start of care.

G0514 – The RN start of care assessment was not completed within 48 hours of receipt of the referral, discharge date, or the physician ordered start of care date. Patient #4's referral was sent via fax on 6.17.25 and included nurse, physical and occupational therapy and aide services but did not identify a specific start of care date. The nurse went to the patient's home and patient requested the start of care be the following day but when the nurse showed up at the patient's house the following day the patient would not let them in. The nurse then called the daughter, who asked them to return when they were able to be at their patient's house. Subsequently, the patient's start of care was not until 7.21.25. Patient #3 had a physician's referral on 7.16.25 for physical therapy services without a start of care date identified. An interim physician's order identified a start of care date for 7.25.25 without notes in the record as to why the initial visit was delayed. Patient #2 had a referral on 5.23.25 for nursing and physical therapy without a start of care date identified. An interim order identified the start of care date as 5.29.25 without documentation of why the start of care was delayed. Patient #6 had a referral on 5.30.25 for nursing services for wound care without a start of care date identified. An interim order was completed for a start of care date on 6.3.25 without documentation as to why the delay of the start of care occurred.

G0580 – The staff did not follow Patient #4's plan of care by not assessing glucometer readings for patterns of hypo/hyperglycemia, completing medication set up every other week, or notifying the physician when the patient's blood pressure was outside of established parameters. When the patient ran out of medication due to the missed visit the staff did not notify the physician of missed medications and glucose monitoring.

G0584 – Patient #1's medication orders did not match what the patient was actually taking, and the nurse did not discard expired medications the patient reported they had not taken for more than 6 months.

G0764 – The home health aides did not have documented competency evaluations in assigned task areas prior to independently performing the tasks with a patient. These tasks included applying orthotic braces, applying a topical ointment and applying a simple dressing.

G0808 – The agency did not document home health supervisory visits at least every 14 days as required.