HHA Survey Trends Report

March 2026

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.

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March Home Health Agency Survey Report

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Total Home Health Agencies in Iowa = 126

Accredited = 49 of 126

Number over 36 months since last recertification = 0

Longest time frame since last recertification = 30 months

There were 3 recertification surveys that had reports available for review. Of the 3 recertification surveys, there were an average of 5 deficiencies cited per survey.

One complaint investigation was reported as being completed in March but was not available for review.

The highest cited deficiency (cited in all 3 surveys) was G0574 related to the plan of care not including all necessary supplies and equipment. You can find examples of noncompliance later in this report.

<u>Deficiencies Cited in March</u>

E017 – HHA Comprehensive Assessment in Disaster

The agency didn't ensure that patients had emergency plans in their homes during home visit observations.

G0528 - Health, Psychosocial, Functional, Cognition

During two of the skilled nurse visits for Patient #1, the documentation lacked wound measurements to the right arterial, proximal dorsum diabetic ulcer. Patient #9's skilled nurse visits on 1.28 and 2.4 lacked documentation of measurements for a left medial buttock pressure ulcer. Patient #3 was admitted for surgery aftercare. The patient’s skilled nurse visits lacked assessments to the identified laparoscopic surgical sites and why they were not performed after the follow up surgical appointment.

The start of care comprehensive assessment identified a small laceration to the right forehead and three pressure ulcers to the coccyx but lacked assessments and measurements of the wounds.

G0536 - Review of Current Medications.

Comprehensive assessments for Patient #8 lacked documentation that a drug regimen review was completed. Patient #1's medication list indicated they took Atorvastatin 20 mg daily when the bottle at their house indicated 40mg and didn't have documentation that the patient took docusate sodium as needed. Patient #2's medication list included Oyster shell + D3 supplement, Ferrous Sulfate 325mg daily, and Lidocaine patches. During the home visit, the surveyor noted their prefilled bubble pack included Citracal + D3 supplement, Ferrous Sulfate every other day and the patient indicated they didn't have lidocaine patches to use. Patient #9's comprehensive assessment lacked documentation of a drug regimen review being completed.

G0548 – Within 48 Hours of the Patient’s Return

Patient #6 was discharged from the hospital on 11.1 but didn't have a resumption of care comprehensive assessment until 11.4.

G0572 - Plan of Care

Three patients reviewed had missed physical therapy visits that their primary physicians weren't notified of.

G0574 - Plan of Care Must Include.

Care plans for four patients reviewed lacked identification of all necessary equipment and supplies including updated medication lists, frequency of oxygen changes, pill cutter, and a life alert button.

The plan of care for two patients reviewed lacked documentation of all equipment and supplies needed including ted hose and cane.

The plan of care for three patients lacked identifying all necessary supplies and equipment including a walker, therapeutic seat cushions, current medications, and an incentive spirometer.

G0580 - Only as Ordered by the Physician.

Patient #1 had a new order for physical therapy evaluation and treatment of two visits per week x six weeks. The patient’s record lacked documentation of physical therapy services being completed. Patient #2's orders included directions that the blood pressure could not be checked using the left arm due to lymph node removal. However, during an observation visit, the nurse checked the blood pressure in the left arm. During a visit for Patient #3 the nurse failed to include all medications ordered in the med planner.

G0584 – Verbal Orders.

The orders for Patient #4 included a 16 french suprapubic catheter. During a skilled nurse visit, they documented using an 18 french catheter and didn't obtain an order for the different size.

G0768 – Competency Evaluation

Competency teaching and evaluation lacked simple dressing changes, feeding, shaving, assistance with orthotic braces and feeding.

G0798 - Home Health Aide Assignments and Duties

The RN failed to identify specific individualized patient needs during home health aide visits such as specific skin care necessary for a pressure ulcer.

G0800 - Services Provided by Home Health Aide

During aide visits, they documented that a transfer was completed but failed to identify how the patient transferred (such as a mechanical lift with two assistance).

G0808 - Onsite Supervisory Visit Every 14 Days

Home Health aide supervisory visits weren't conducted at least every 14 days for two patients reviewed.