HHA Survey Trends Report

September 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.

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September Home Health Agency Survey Report

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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. There is one home health agency that is at the 36-month recertification period and 18 additional that are between 30-35 months.

There were two recertification and one complaint survey available for review. The complaint survey did not result in deficiency and the two recertification visits resulted in 8 total deficiencies.

As a reminder, survey activity has stopped other than complaints that are triaged as an immediate jeopardy or harm level due to the Federal Government shutdown. If the shutdown goes for a longer period, we will check in with DIAL on plans for resuming survey activity.

Deficiencies Cited in September

G0528 – The agency did not document weekly measurements of a wound to the patient's left lateral lower leg in skilled nurse progress notes.

G0572 – The plan of care for Patient #7 included aftercare following a joint replacement surgery. The hip dressing was to be removed on 8.5.25 with the incision left open to air and may be washed with antibacterial soap and water and patted dry. The skilled nursing visit note on 8.8.25 documented a non-removable dressing was in place to the left hip and was dry and intact. The nurse did not remove the dressing as ordered. Patient #1's plan of care included medication orders for Loratadine 10 mg daily as needed for allergy symptoms. During medication set up, the nurse included Loratadine 10 mg daily in the planner and did not notify the physician of the variance in the medication frequency that was identified on the plan of care.

G0574 – The plan of care for Patient #4 did not include all supplies and equipment used including bed rails, wheelchair cushion, lift chair, and wheelchair ramp. Patient #10 did not have an order for the use of oxygen at 2 liters per nasal canula.

G0580 – Patient #9's skilled nurse visit note stated they reported pain at 8/10. The patient reported using Tylenol and heat with some relief. The record did not include physician's orders for pain relief interventions for right leg pain.

G0764 – The home health aides did not have documented competency evaluations for home exercise programs.

G0800 – Patient #7's home health aide visit note did not include if the patient received a shower or a sponge bath as both were checked as complete. Patient #4's home health aide visit notes lacked documentation that the patient received a shower or sponge bath and did not include why the task was not performed according to the plan of care.

G0808 – Patient #3's skilled nurse visit notes included supervision of home health aides 15 days after the previous one and 16 days after the plan of care period instead of every 14 days as required by the plan of care.

G1024 - Review of home health aide visit notes for several patients lacked the aide’s signature and credentials on the note.