# HHA Survey Trends Report

## December 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

# December Home Health Agency Survey Report

by Kellie Van Ree, Director of Clinical Services

Total Home Health Agencies in Iowa = 130

Accredited = 50 of 130

Number over 36 months since last recertification = 7

Longest time frame since last recertification = 38 months

Number of Agencies at 36 months since last recertification = 4

There were 4 recertification surveys completed for home health providers in December. One of the agencies was deficiency free, while the others averaged 5 deficiencies per agency. Additionally, there was 1 complaint survey available for review that did not result in a deficiency.

Among the recertification surveys that resulted in deficiency, there were a few commonalities. Each agency was cited for assessments related to wound assessment documentation and ensuring that measurements of the wounds were included.

Additional tags that were cited in all recertifications with deficiencies include drug regimen reviews and ensuring that all care items were included in the plan of care. You can find more specific information on these below.

## Deficiencies Cited in December

### G0528 Health, Psychosocial, Functional, Cognition.

The comprehensive assessment and skilled nurse visit notes lacked documentation of wound care assessments and measurements when a patient had a pressure ulcer.

Patient's wound assessments did not include full measurements including the length, width, and/or depth of the wound during skilled nurse visits.

Patient #4 had a pressure ulcer and according to agency policy weekly wound assessments would include length, width, and depth along with the measurements for any undermining or tunneling. During two pressure ulcer assessments, undermining was noted that lacked documentation of the undermining measurements.

**G0536 Review of Current Medications.**

Review of Current Meds. Drug regimen reviews completed on three patients did not include accurate medication reconciliation records when patients took medications different from the bottle recommendations and were not taking medications that were listed on the medication record.

Drug regimen reviews did not include an accurate review of all medications taken by the patient, especially when medications were identified in the home that were not on record.

Review of Current Meds. Drug regimen reviews completed on two patients did not include all medications taken by the patients.

**G0574 Plan of Care Must Include.**

The patient's plan of care did not include the correct code status according to the patient's wishes, or another patient's need for a pill cutter, and a Cefaly device for migraines.

The plan of care did not include all items used by the patient including pill cutters, diabetic supplies, elastic hose, incentive spirometer, tubigrips, lift chair, wheelchair cushions, and wound care supplies.

Patient's plan of care did not include all equipment that the patient's needed/used including a heating pad, chair cushion, urinal, CPAP, reacher, glucometer, and diabetic supplies.

**G0574 Only as Ordered by the Physician.** Physician orders did not include physician orders for a heating pad. Another patient's visits did not include standing blood pressure when the physician orders included assessing orthostatic blood pressure measurements.

**G0800 Services Provided by Home Health Aide**

The home health aide visit notes lacked documentation of weights as included in the plan of care. Another patient's documentation lacked completion of shower/partial bath or bed bath.

The home care aide did not follow the patient's plan of care by providing a shower when the plan of care only indicated a partial bath and failed to document a partial bath or shower during the visit.

**G0808 Onsite Supervisory Visit Every 14 Days** Onsite supervisory visit every 14 days. The agency failed to document home health aide supervision visits every 14 days.

**G0818 Home Health Aide Supervision Elements** The patient's records did not reflect that all home health services were supervised and included all supervisory elements included in the plan of care.

**G1022 Discharge and Transfer Summaries.** The program policy indicated that when a patient was transferred to another facility, they would send a transfer summary within two business days of when they are aware of the transfer. Patients were transferred to hospitals and when the transfer summary was sent, it exceeded the two business days. Additionally, the transfer summary was sent to the primary physician instead of the hospital.