HHA Survey Trends Report

February 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.

Website:

www.LeadingAgeIowa.org

Tel: (515) 440-4630

11001 Aurora Avenue

Urbandale IA, 50322

February Home Health Agency Survey Report

by Kellie Van Ree, Vice President of Clinical Services and Education Strategy

Total Home Health Agencies in Iowa = 126

Accredited = 48 of 126

Number over 36 months since last recertification = 0

Longest time frame since last recertification = 35 months

There were 9 recertification surveys that had reports available for review. Of the 9 recertification surveys, there were an average of 3.9 deficiencies cited per survey.

Three complaint investigations were reviewed as well, which included 2.6 average deficiencies cited during the investigations.

Reviewing the number of active providers in the state revealed that during the calendar year 2025, 5 home health agencies closed, representing 4% of the overall home health agencies. There was only 1 new home health agency started during the same period.

The highest cited deficiency (cited in 7 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.

Deficiencies Cited in January

G0406 - Patient Rights

The agency didn't ensure the patient had the right to participate in, be informed of, and consent or refuse care in advance of treatment.

G0434 – Participate in Care

Patients' #1, #2, #3, #4, #5, and #6 didn't have admission or annual consents for treatment in their records.

G0514 – RN Performs Assessment

An initial visit wasn't completed within 48 hours of the referral for patient #3.

G0528 - Health, Psychosocial, Functional, Cognition

Wound measurements for patient #3 included length and width but failed to include depth measurements.

G0536 - Review of Current Medications.

During medication regimen reviews for patient #3, the agency included an order for Morphine 15 mg every 6 hours as needed for pain, however, the patient indicated they no longer had that order and showed the surveyor a prescription for hydrocodone.

The nurse didn't accurately complete medication regimen reviews when the agency medication list differed from what the patient indicated they were taking.

The drug regimen review included medications that were not being used by the patient.

G0546 – Last 5 Days of Every 60 Days Unless:

A recertification OASIS data collection was completed on day 54 and not within days 56-60 as required.

G0548 – Within 48 Hours of the Patient's Return

The patient had a transfer OASIS completed on 9.19.25 and a communication note indicating the patient was discharged from the hospital on 9.26.25. The resumption of care was not completed until 10.1.25.

G0572 - Plan of Care

The physician wasn't notified of a missed aide visit for 2 patients.

Missed visits were not reported to the physician for 3 patients reviewed.

A physical therapy order was received on 12.28.25 that was not completed until the week after on 1.4.26. A different patient had an order for physical and occupational therapy services once a week and the record lacked documentation of a physical therapy evaluation being completed. Patient #4 also had orders for physical therapy 1 visit per week for 3 weeks and 2 visits per week for 1 week that were not followed.

G0574 - Plan of Care Must Include.

Patient's plan of care didn't include all necessary supplies and equipment including a rice bag as a heating device, handheld shower head, lifeline, incontinence supplies, and diabetic supplies.

Patient's plan of care didn't include all necessary supplies and equipment including a scale, the dosage for a medication, nebulizer, and incontinent products. Additionally, the medication orders on the plan of care were not correct with what the nurse placed in the med planner.

The plan of care didn't include all necessary equipment and supplies including a pill cutter, eye drops, and a medication planner.

The plan of care didn't include all diagnosis for patient #5.

The plan of care for patient #3 didn't include all identified medications.

The plan of care didn't include all medications and supplies the patient used including a surgical shoe, handheld shower, oxygen concentrator and portable oxygen.

The plan of care failed to include all supplies and equipment used by the patients including a heating pad, incontinence products, spirometer, compression socks and a ramp to enter the home.

G0580 - Only as Ordered by the Physician.

Physician's orders for resumption of care were not obtained for 2 patients.

The physician wasn't notified of a weight gain as included in the plan of care.

Services were not provided only as ordered by the physician, including occupational and physical therapy evaluations and service plans that were not signed by the physician.

The patient's record lacked completion of physician orders in accordance with the plan of care including when wounds were not properly assessed.

G0596 – Revisions Communicated to Patient and MDs.

The physician wasn’t notified of missed medications.

G0622 – Name/Contact Information of Clinical Manager

The agency didn't provide a patient with the clinical manager’s name and contact information in their admission folder that was left in the patient's home.

G0710 – Provide Services in the Plan of Care

The nurse failed to update physician orders based on the time the medications are taken by the patient.

G0768 – Competency Evaluation

The agency didn't ensure staff training and competencies were evaluated for tubigrips.

G0798 - Home Health Aide Assignments and Duties

The home health aide care plan did not include all necessary tasks specific for the aide to complete during the visits.

The home health aide care plan included instructions to assist with exercises as directed by the physical therapist but didn’t have specific instructions on what exercises those are.

The home health aide plan of care failed to include assistive devices necessary to transfer the patient.

G0800 - Services Provided by Home Health Aide

The aide visits notes didn't include all items assigned on the aide assignment sheet.

The tasks were not completed according to the physician's order as the home health aide documented the incorrect bath/shower type completed.

Home health aide notes lacked identification of tasks that were completed and if any were not during their visits.

G0808 - Onsite Supervisory Visit Every 14 Days

Skilled nurse visit notes didn't include documentation of home health aide visits at least every 14 days as twice they were a day late.

Skilled nurse visit notes failed to include documentation of home health aide supervision in November and December.

G0818 - Home Health Aide Supervision Elements

During supervisory visits, the nurse didn’t include all required elements established in their Home Health Aide Supervision policy for 4 patients and multiple visits.

The home health aide supervision notes lacked all required elements in the agency's policy for 2 patients and several visits.

The agency didn't include documentation of all required home health aide supervisory elements in their notes.

G1012 - Required Items in Clinical Record.

The agency's procedures for wound care and assessments indicated that wounds would be assessed, measured, and documented weekly. Patient #1's skilled nurse visit notes lacked measurements and assessments for 5 wounds and Patient #3's skilled nurse visit notes lacked assessment and measurement for 1 visit.

Patient #3 didn't have weekly wound assessments for 4 weeks in December and 1 in January.

G1022 - Discharge and Transfer Summaries.

The agency failed to send a discharge summary within 2 business days of being aware of a transfer or discharge and to the health care professionals within 5 business days for 2 patients.

A discharge summary wasn't sent to the agency that assumed care when a patient transitioned to another agency within 2 days of being aware of the transfer.

G1024 - Authentication

Home health aide visits notes were not electronically signed when entered into the electronic record.