HHA Survey Trends Report

January 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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January Home Health Agency Survey Report

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Total Home Health Agencies in Iowa = 130

Accredited = 50 of 130

Number over 36 months since last recertification = 3

Longest time frame since last recertification = 38 months

Number of Agencies at 36 months since last recertification = 4

There were 5 recertification surveys that had reports available for review. Additionally, 6 recertification surveys were conducted but the reports are not posted yet. Of the 5 recertification surveys, there were an average of 3.8 deficiencies cited per survey.

The highest cited deficiency (cited in 4 of the 5 recertification surveys) was G0536 related to medication regimen reviews. In each example (additional details provided in the report) the agency didn't have accurate medication records according to observations and/or patient interviews.

Deficiencies Cited in January

E008 Plan Based on All Hazards Risk Assessment.

Review of agency documents for emergency preparedness failed to include completion of an Hazard Vulnerability Analysis (HVA) in 2024 and 2025.

E017 HHA Comprehensive Assessment in Disaster.

The emergency preparedness plan did not include a policy on completing individualized emergency plans as part of the patient assessment.

G0520 5 Calendar Days After Start of Care.

Patient #6 started care on 7.29.24 and a comprehensive assessment was not completed until 8.7.24 or 9 days after the start of care. Patient #2 started care on 1.6.25 with a comprehensive assessment dated 1.15.25 or 6 days after the start of care.

G0536 Review of Current Medications.

During drug regimen reviews for 2 patients, the agency failed to correctly reconcile medications including medications that were no longer being used or including medications that were being used.

Patient #2's skilled nurse visit note documented that a drug regimen review was completed without discrepancies. During the surveyor's supervisory visit, a discrepancy was noted on the patient's quetiapine fumarate frequency as the agency documentation included daily dosing, but the bottle indicated twice daily dosing. Patient #3's medication profile included famotidine, but the nurse did not set up famotidine during observations. The patient indicated that they have not taken it for more than 2 months.

Review of the current medications included discrepancies that were not included on the medication list.

Patient #7's recertification comprehensive assessment included documentation of medication side effects and compliance but lacked documentation reviewing interactions, ineffective medications and duplicate medications.

G0572 Plan of Care

Patient #5's physician was not notified of missed skilled nurse visits.

Patient #1 was scheduled to have home health aide visits 7 days per week, and a skilled nurse visit once per week. During review of visits, it was identified that several home health aide visit notes were missing and the patient's physician was not notified of missing visits.

G0574 Plan of Care Must Include.

Patient #3's plan of care failed to include emesis bags and urinals under medical supplies and equipment. Patient #6's plan of care failed to include incontinent supplies. Patient #2's plan of care did not include a scale and lift chair.

G0580 Only as Ordered by the Physician.

The plan of care for patient #4 included the skilled nurse assessing for weight changes which was not completed upon review of visit notes.

Patient #7's physician's orders covered physical therapy services, but additional orders were not received when therapy services exceeded the ordered time frame. Additionally, skilled nurse visit notes included documentation of using heat and/or ice on right knee pain, but the patient did not have a physician order for using heat and ice.

G0706 Interdisciplinary Assessment of the Patient

The skilled nurse visit note identified a laceration over the left eye with sutures but did not include documentation of an assessment or dressing that was in place.

G0798 Home Health Aide Assignments and Duties

Patient #1 and #7's aide care plan included weekly foot care, but did not identify what foot care specifically needed completed.

G0800 Services Provided by Home Health Aide

The aide plan of care identified a task for the home health aide to trim fingernails weekly on Wednesdays. This task was not completed each Wednesday and was included as completed on other visit days of the week. Patient #1's aide care plan included a task of washing as needed. The visit notes on 1.6 did not have washing marked as completed or why it was not completed.

G0808 Onsite Supervisory Visit Every 14 Days

Skilled nurse visit notes did not include documentation of home health aide supervision every 14 days as required.

Home health aide supervisory visits were not completed every 14 days as required for two patients.

G0818 Home Health Aide Supervision Elements

Patient #2's skilled nurse visit notes identified that home health supervision was completed but the notes lacked documentation of all required supervisory elements including following the plan of care, maintaining open communication, demonstrating competency of assigned tasks, complying with infection prevention and control policies, reporting changes in patient condition and honoring patient rights.

G1012 Required Items in Clinical Record.

Skilled nurse visit notes initially included 5 wounds along with measurements. Subsequent visits lacked documentation of all 5 wounds or if they were healed.

G1022 Discharge and Transfer Summaries.

Patient #7 was sent to the hospital and the agency was notified by the patient's spouse of hospitalization on 7.11.25. The transfer assessment was completed on 7.11.25 but was not sent to the patient's primary care physician within 2 days as required. The patient was also admitted to skilled nursing on 8.8.25 and the agency didn't send the transfer summary to the skilled nursing provider.