5 STAR CONSULTANTS
HEALTHCARE SPECIALISTS

Home Health CoPs Deficiencies Seen

Tips and Strategies for Compliance

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NEVER ATTACK A
PROBLEM WITHOUT
ALSO PRESENTING
A SOLUTION

Jim Rohn

OBJECTIVES

- Principals of HH New CoPs
- Deficiency classifications and implications
- Deficiencies seen to date
  - Specific deficiencies
  - Challenging Conditions and Standards
  - Strategies to meet compliance
  - What to do to make your agency in state of continued survey readiness

CoP Philosophy

Patient- Centered,

Data-Driven,

Outcome Oriented

CoP Philosophy

- Process that promotes high quality patient care at all times for all patients
- Continuous, integrated care process across all services, based on patient centered assessment, care planning, service delivery and QAPI
- Interdisciplinary approach recognizing skills of all of the team
  - Think Care Management Teams!
  - Coordination of Care!!!!

CoP Philosophy

- Outcome oriented- make quality improvements through QAPI specific to each HHA in order to improve patient outcomes and ensure safety
- Utilize Data Driven CASPER reports to improve outcomes

Deficiency Classifications

Standards and Conditions

Deficiencies

You will have standard level deficiencies in this age of surveys so don't expect zero!

But…. don't be vulnerable for repeat Standard Level Deficiencies, Condition Level Deficiencies or Immediate Jeopardy!

Level 1 Standards

Highest priority standards

- **Include :**
  - Process standards that are associated with high-quality patient care, and
  - Administrative standards that closely relate to the agency's ability to deliver high-quality patient care
- Surveyors must review all of these standards during a standard survey

Examples:

- Investigation of complaints – under patient rights
- Initial assessment visit – under comprehensive assessment of patients
- Plan of care – under care planning, coordination, quality of care

Level 2 Standards

Next Highest Priority Standards

- At a minimum, compliance with Level 2 standards is evaluated if deficiencies are found with Level 1 standards
- Guidelines for further investigation
- Condition-level guidance (when to consider citing a condition)
- Related conditions for further investigated

Extended Survey – when condition-level is cited all conditions are examined.

Condition Level vs. Standard Level Deficiencies

- Each condition has standards that are associated with it
  - G tags
- Standard level deficiency
  - Not compliant with one of the standards (G tags) under a condition
- Condition level deficiency
  - Non-compliant with:
    - The entire condition or,
    - Several of the standards associated under the condition or,
    - Scope and severity warranted

Deficiencies Standard Level

Standard level:

- Must write a plan of correction
- May or may not have a follow up survey to check compliance and completion of action plan
  - Follow-up depends on the scope and severity of the deficiency

Deficiencies
Condition Level

Condition Level:

- Must write a **detailed** plan of correction
- The state or accrediting body notifies Medicare that agency has a condition level deficiency
  - Agency is at risk of losing Medicare certification if the condition is not fixed quickly – typically within 10 days
- Typically will have a return visit in 30-60 days, so fix prior to receiving report

Immediate Jeopardy

A situation where the agency's non-compliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a patient

- Follow-up survey will typically be 7 – 23 days!
- **MUST** have been fixed
- You will likely get your report quicker than 10 business days, so work on your plan of correction immediately, BUT do NOT wait to fix the deficiencies!

Sanctions

Can be given for:

- Condition level deficiency and even Repeat standard level deficiency
- Will always be given for Immediate Jeopardy
- Types:
  - Directed education
  - Directed plan of care
  - Interim management provided by CMS designee
  - Monetary
  - Suspension of payments for all new admissions

Monetary Penalties
$500-$21,800 per Day!

- The per-day penalty begins accruing on the final day of the survey that identifies non-compliance
- The penalty continues until the agency achieves compliance or when the provider agreement is terminated
- Agencies have up to six months to comply, beginning from the last day of the original survey that determined non-compliance or CMS will terminate the agency
  - Often with Immediate Jeopardy the timeframe for termination is much quicker

Immediate Jeopardy

Example:

- Agency Administrator was not providing daily management to HHA as was overseeing many departments
- Director Patient Care was new and inexperienced in HH
- One of the 2 RNs was new and inexperienced in HH

Immediate Jeopardy

Example:

3 Immediate Jeopardy and 7 Conditions

- 3 potential or harm to patient:
  - Wound odor, more drainage- no physician notification- patient outcome-wound infection
  - Volatile, high BS- no physician notification
  - OT on visit- notes adverse patient signs and symptoms (BP 80, RR 32, sweating profusely, very weak). Calls DPS- who says to tell husband to tell physician at next office visit in 2 days. OT leaves and documents above.

Home Health Deficiencies

Federal Top Citations

- G590 - Promptly Alert Relevant Physician Of Changes
- G574 - Components Of POC
- G716 - Clinical Notes
- G536 - POC Includes Review Of Current Medications
- G710 - Services To Be Provided In Accordance With POC
- G572 - Each Patient Has A POC Signed By Doctor
- G584 - Verbal Orders Accepted In Compliance With State Laws /Home Health Policies & Procedures

Federal Top Citations

- G608 - Services are Coordinated To Meet Patient Needs
- G682 Precautions To Prevent Transmission Of Infections & Communicable Diseases
- G446 Patient Has Right To Be Advised Of Contact Into For Agencies (QIO, Advocacy, Etc.)
- G580 Drugs Treatment Services Administered Only As Ordered By Physician

Home Health Deficiencies

Examples Seen

§484.105 - Organization & Administration of Services Standard – (e)
Services Under Arrangement

(2)An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients…must maintain overall responsibility for the services provided…The agency, org,… providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program.

(3) The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients.

Deficiency
G978
Written Agreement

- Upon contract review, 5 out of 5 contracts did not include the following:
  - Denied Medicare or Medicaid enrollment
  - Been excluded or terminated from any federal healthcare program or Medicaid
  - Had its Medicare or Medicaid billing privileges revoked;
  - Been debarred from participating in any government program

Key Points

- ***Review All Contracts to ensure that this information is in contract.***
- ***OIG exclusion list includes individuals and entities. Check at time of contract & regularly***. https://exclusions.oig.hhs.gov/

§484.110 - Clinical Records

Standard - (b) Authentication

All entries must be legible, clear, complete, and appropriately authenticated, **dated, and timed**.

Authentication must include a **signature and a title (occupation)**, or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.

Deficiency G1024 Clinical Records Authentication

- Upon medical record review, 1 of 7 patients, the OT signature on the note in the computer was the contract company name not the individual OT's name and title.

Key Points

- Ensure employed staff as well as Contract staff are documenting their name and title.
- Orientation to contract staff, as well as in contract.

§484.45 - Reporting OASIS Information
Deficiency
G372
Encoding and Transmitting OASIS

- 37 of 360 OASIS (> 10%) transmitted did not show evidence they were transmitted within 30 days of completing the assessment. OASIS validation reports contained a warning for these OASIS for transmission greater than 30 days.
- There was not evidence the HHA encoded & electronically transmitted each completed OASIS assessment to the CMS system within 30 days of completing the assessment. During the quarter, 21.28% were not transmitted within 30 days (October=35.53%).

Key Points

- Tight Process in place to ensure that OASIS are submitted.
- Audit monthly.
- Checks and balances!

§484.50 – Patient Rights
Standard- (a)
Notice of Rights

(1) Provide the patient and the patient's legal representative (if any), the following information during the initial evaluation visit, in advance of furnishing care to the patient:

(ii) **Contact information for the HHA administrator**, including the administrator's name, business address, and business phone number in order to receive complaints.

§484.50 – Patient Rights
Deficiency
G414

484.50(a)(1)(ii)

Patient Rights - HHA administrator contact information

- Upon observation, there was no evidence that the agency provides to the patient and the patient's legal representative (if any), the contact information for the business address for the HHA Administrator in order to receive complaints.

§484.50 – Patient Rights
Standard - (c)
Rights of the Patient

(5) Receive All Services Outlined In the Plan of Care.

CMS final rule information:

- Intent is to assure that pts can be informed about and involved in establishing & revising their plan of care as a whole.
- The **patient has a right to be involved with all facets of the care** they receive. It is the HHA's responsibility to discuss the level of involvement that patients and their representatives want to have in the plan of care.
- This includes factors such as how much the patient is capable of understanding and the extent they wish to be involved with the development and **updates to the plan of care**.

§484.50 – Patient Rights
Deficiency
G436

§484.50(c)(5)

Patient Rights – Receive All Services in Plan of Care

- The statement of Patient Rights did not include the patient had the right to receive all services outlined in the plan of care.
- There was no evidence in the clinical record that the patient, and representative when applicable, was included in updates in the plan of care.

§484.50 – Patient Rights
Standard- (c)
Rights of Patient

(4) Participate in, be informed about, and consent or refuse care **in advance of and during treatment**, where appropriate, with respect to:

(i) Completion of all assessments;

(ii) The care to be furnished, based on the comprehensive assessment;

(iii) Establishing and revising the plan of care;

(iv) The disciplines that will furnish the care;

(v) The frequency of visits;

(vi) **NEW** Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;

(vii**) NEW** Any factors that could impact treatment effectiveness; and

(viii) Any changes in the care to be furnished.

Deficiency
G434
Patient Rights - Participate In Care

Level 1 Deficiency

- Upon medical record review, 8 of 17 did not have evidence that the patient had the right to, participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to all required elements.
  - There was no evidence of the patient being informed of the frequency of proposed disciplines.
  - Consent forms signed at SOC is blank in areas of discipline frequency and no evidence in subsequent documentation of frequency.
- Upon medical record review, 5 of 5 patients admitted within the past year no evidence that the patients were informed about the frequency of visits for the disciplines to provide care, the frequency on their consents were blank.

§484.50 – Patient Rights
Standard- (c)
Rights of the Patient

(10) Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides:

(i) Agency on Aging,

(ii) Center for Independent Living,

(iii) Protection and Advocacy Agency,

(iv) Aging and Disability Resource Center; and

(v) Quality Improvement Organization.

Deficiency
G446
Patient Rights – Contact Info
Federal / State-Funded Entities

§484.50(c)(10)

- The home folders did not include that the patient was advised of the names, addresses and telephone numbers of the Agency on Aging, Center for Independent Living, or the Quality Improvement Organization.
- There was no evidence that the agency provides the patient of the name, address and telephone number for the Agency on Aging.

§484.50 – Patient Rights Standard- (c) Rights of the Patient

§484.50(c)(7)

(7) Be advised of:

(i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA,

(ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA,

(iii) The charges the individual may have to pay before care is initiated; and

(iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the pt and rep (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f).

§484.50 – Patient Rights
Deficiency G440
Standard- (c)
Rights of the Patient

§484.50(c)(7)

Patient Rights

- Upon medical record review, 10 of 17 did not have evidence of documentation in the patient record that before the care was initiated, the HHA informed the patient, orally and in writing, of financial requirements and expectations.
- There was no evidence patient was informed of charges the individual may have to pay before care was initiated. Consent form signed at SOC is blank in area of Patient Pay.

§484.55 – Comprehensive Assessment of Patients
Standard (a)(1)
Initial Assessment Visit

1. An RN must conduct an initial assessment visit to determine the immediate care and support needs of the patient; & for Medicare patients, to determine eligibility for the Medicare HH benefit, including homebound status.

a. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.

§484.55 – Comprehensive Assessment of Patients
Deficiency- G514
Standard (a)(1).
Initial Assessment Visit

Level 1 Deficiency

- Upon medical record review, 1 of 16 did not have evidence the initial assessment visit was held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.

§484.55 Comprehensive Assessment of Patient
Standard–(c)
Content of the Comprehensive Assessment

The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:

(5) A review of all medications the patient is currently using in order to identify any potential adverse effects

§484.55(c)(5)

G536 – POC includes review of current medications

- **Level 1 Deficiency**

§ 484.55(c)(5)
Deficiency
G536 - POC Includes Review of Current Medications

Level 1 Deficiency

Upon medical record review, 5 of 17 did not have evidence of a review of all medications that the patient was currently using.

- Profile included Normal Saline flush 2-3 times a day IVP *without including dose*.
- Profile included Heparin Flush 100u/ml, *5000*units every day IVP. *Dosage was supposed to be 500 units.*
- Profile included Tylenol every 4-6 hours PRN without a qualifier for PRN.
- Profile included Loratadine, Lyrica, Neurontin, prochlorperazine, Santyl, Senna, Senna Plus *without including a dose, frequency or route*.
- Profile included Insulin Lispro 1-16 units SQ before meals *without defining the dosage parameters.*

Deficiency
G536 **POC Includes Review of Current Medications**

Key Points:

- An ongoing medication review is completed for all patients
  - ✓ ALL dosages need to be reviewed by RN to ensure accuracy/consistency
- In Therapy-only cases, the RN must document medication review
- All PRN medications include when the PRN medication should be administered and reason
- O2 is listed on the medication profile
- The physician is notified of any medication discrepancies, side effects, problems, or reactions

Deficiency- G536
POC Includes Review of Current Medications

Key Points:

- Patient has a medication list that is consistent with the list in the clinical record
- All prescription and Over the Counter (OTC) medications must be on the medication list
- IV cases – very vulnerable in HHA's! Ensure IV competency, frequent in-service **AND** QAPI indicator for IV Therapy
- Management of Medications so critical to patient safety- Consider a PIP!

§484.60 – Care Planning, Coordination of Services, and Quality of Care

Deficiency- G572
§484.60(a)(1) Each Patient Has a POC Signed by Doctor

Level 1 Deficiency

Plan of Care Must Include Following Examples:

Upon medical record review, 17 of 17 did not have evidence of an individualized plan of care.

- PRN
  - Order for SN to assess for following risk factors at SOC and/or PRN… did not include a PRN qualifier.
  - Order for SN to assess patient/caregiver knowledge of diabetic management at first visit and review PRN did not include a PRN qualifier.
  - Order for sacrum wound care daily and PRN did not include a PRN qualifier
- Orders for current certification period starting x/x were not included on ROC POC.
- Order for therapy to instruct use of ice for pain/edema control did not include location, duration and frequency for ice.

Deficiency
Individualized POC – Plan of Correction

- One-on-one in-service will be provided to affected staff and a staff meeting will be conducted for clinical staff re: Completing the Resumption of care orders to obtain orders for all treatments and interventions required for care of the patient. Writing specific orders for all procedures, i.e., Ice therapy(where, how often, how long, etc.) Writing PRN frequency orders & reasons.
- Director Patient Services or designee will review;
  - 100% of the Resumption of Care orders for 4 weeks to ensure that there is documentation of the orders and interventions being carried over on to the new ROC POC. Threshold - 100%. Once threshold is met, will continue 50% of Resumption of Care orders to ensure accuracy quarterly.
  - 25% of active patients clinical records will be reviewed quarterly to ensure that orders are specific and PRN visit frequency & reasons are written. Threshold - 100%.

§484.60 (a)(2)
Plan of Care Must Include the Following

(2) The individualized plan of care must include the following:
(xii) (NEW) description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.

Key Point:

- Ensure that there are Agency processes for standardization to include this risk on the Plan of care.
- Educate all clinicians responsible for assessment/ POC development.
- Audit POC's to ensure Risk is appropriately individualization for patients.

There is a Written Plan of Care for Each Patient Accepted to Services. §484.60,(a) 1,2,3
G570, G572, G574, G576

Key Points to Ensure:

- All physician orders are obtained prior to the initiation of services
- Address all issues identified in the comprehensive assessment
- Orders for all disciplines include the amount, frequency, and duration of the service provided
- Therapy orders include the specific procedures and modalities to be provided
- PRN orders for medications and treatments have specific numbers and reasons

There is a Written Plan of Care for Each Patient Accepted to Services. §484.60,(a) 1,2,3
G570, G572, G574, G576

Key Points to ensure:

- Interventions and Goals address the specificity of the patient's needs.
- All medications, treatments, and services are administered as ordered by the physician
  - ✓ Consistent with visit notes and comprehensive assessments
  - ✓ Include verbal orders
- Communicate all missed visits to the physician to determine if the plan of care needs to be altered

§484.60(b)
Deficiency G578
Conformance With Physician Orders

Level 1 Deficiency

- 6 of 7 patients reviewed did not have evidence that care provided conformed with the physician orders; SN/PT were performing pulse oximetry every visit with no orders for this procedure.
- **Plan of correction**: Agency order for VS for all patients POC's will be revised to add O2 sat at every SN/PT visit. Notify physician for SpO2 <90%. Patient individualization will occur re parameter as applicable to physician orders.
  - Educate staff on using the new standard order that includes order for O2 sat with VS.
  - Clinical Manager will review 100% of POC for 4 weeks to ensure that orders are being placed for O2 sats. Threshold - 100%. Once threshold is met, will continue to audit 25% of POC quarterly.

§484.60(b)(1)
Deficiency - G580
Drugs/ Treatment/ Services Administered Only as Ordered by Physician

Level 1 Deficiency

- In Addition to Medication deficiencies cited under 484.55(c)(5) G536 - POC includes review of current medications, many of the deficiencies would cross over to this CoP as medications were not conforming to physician orders.

§484.60(b)(3)(4)
Deficiency G584
Verbal Orders Accepted in Compliance with State Laws / Home Health Policies & Procedures

(4) ….physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law & the HHA's policies, must **document the orders in the patient's clinical record, and sign, date, and <u>time the orders</u>**.

- **Ensure** that actual times are being documented on orders!

§484.60(c)(1)
Deficiency **G588**
As Ordered By A Physician (can also tie to Physician Notification G590)

Level 2 Deficiency

Upon medical record review, 8 of 17 did not have evidence that the agency must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

Frequency of physician visits ordered are not followed:

- SN ordered for 3x week and only 2 visits made week 4 and 5, without evidence physician notified.
- PT ordered for 2x week and only 1 visit made week 4, without evidence physician notified. S
- SN ordered 1 visit every other week and no visit documented between week 4 and week 6 and no evidence of physician notification.

§484.60(c)(1)
Deficiency G590
Physician Notification

Level 2 Deficiency

- In 4 of 6 clinical records reviewed, there was documentation of patient changes noted that were not communicated to the physician:
- PTA noted patient has new increased edema, fatigue and coughing during visit
- BS 462 documented by SN; parameter to notify physician 450
- Pain at level 6-8 for 4 visits without notification to physician
- Patient taking new OTC that is not reported
- Patient wound is larger on measurement with more drainage

§484.60 c- 1,2,3
Deficiency G590
Review and Revision of the Plan of Care Physician Notification

(1)The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

Key Point:

- This is a Level 2 deficiency however is frequently the underlying cause for Standard & Condition level deficiencies and Immediate Jeopardy.
- Ensure that the Care Team is communicating patient issues to each other ongoing and reporting to the physician, with return communication.
- Document all of the team coordination and physician notification.
- Early and frequent physician notification is also instrumental in improving patient and agency outcomes for emergent care and hospitalization.

§484.60(d)
Deficiency G600
Coordination of Care

The HHA MUST:

(1) Assure communication with all physicians involved in the plan of care.

(2) Integrate orders from all physicians involved in the plan of care and interventions provided to the patient.

(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of pt needs & factors that could affect pt safety & treatment effectiveness & the coordination of care provided by all disciplines.

(4) Coordinate care delivery to meet the patient's needs, & involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.

(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education & training provided by the HHA, as appropriate, regarding the care & services identified in the plan of care.

§484.60(d) Deficiency G600 Coordination Of Care

- Upon medical record review 14 of 17 did not have evidence in the patient record of coordination of care by the HHA. There was not evidence that the disciplines talked to each other or the physician about the care the patient was receiving and coordinating services for maximum benefit to the patient.
- Upon medical record review, 2 of 17 did not show evidence of coordination of care by the agency.
  - The RN documented the plan for the next visit included filling the med planner. There was *no evidence of care coordination between the RN and the LPN prior to the LPN visit* and the LPN visit note did not show evidence of filling the med planner.
  - The MSW visit note included the caregiver planned to meet with the home health aide regarding helping the patient put on and take off her brace. The *MSW did not communicate this information to the RN* or the Aide, instead instructing the caregiver to contact the office to schedule training for the aide.

§484.60(e) G612 Written Information to the Patient

The HHA must provide the patient and caregiver with a copy of written instructions outlining:

(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.

(2) Patient medication schedule/ instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA.

(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.

(4) Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs.

(5) Name and contact information of the HHA clinical manager.

§484.60(e)
Deficiency G612
Written Instructions to Patient

- Upon medical record review, 4 of 6 did not show evidence that patient was given a written schedule and instructions of medications, and other pertinent instructions related to the patient's care – such as Home Exercise Program, and treatments, including wound care.
- On home visits, the home folder did not include written a visit schedule, patient medication schedule, treatments and any other pertinent instruction, or contact information for Clinical Manager.

Deficiency G680
§484.70
Infection Prevention and Control

The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases.

- 3 Standards :
  - G682 484.70(a) Prevention
  - G684 484.70(b)(1)(2) Control
  - G686 484.70(c) Education

Deficiency Examples Infection Control & Prevention

- Agency collected infection event reports- which included what infection type was. There was no evidence that initial signs and symptoms, notification to physician, laboratory tests and /or treatment prescribed initiated the infection event report, were documented in event reports or in 2 of 6 clinical records.
- Agency did not have infection reports compiled in order to analyze trends and improve potential infection control and prevention procedures. Individual infection event reports were placed in QAPI folder with no further information.
- Agency did not have evidence that 100% of the staff were educated on infection prevention and transmission of communicable disease.

§484.70 Infection Prevention and Control

Key Points:

- Perform supervisory visits frequently as often infection control breaks in home
- Patients state that they were not taught specifics about infection control/prevention; ensure staff has education tools, such as "teach back" tools; ensure all staff teach infection control each visit.
- Integrate infection control into QAPI:
  - ✓ Utilize data driven such as development of UTI
  - ✓ Surveillance- ensure process that all clinicians understand and complete.
  - ✓ Ensure quarterly trending.

§484.75
Skilled Professionals

Skilled professionals must assume responsibility for, but not be restricted to, the following:

1. Ongoing interdisciplinary assessment of the patient
2. Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s)
3. Providing services that are ordered by the physician as indicated in the plan of care
4. Patient, caregiver, and family counseling
5. ***Preparing clinical notes***
6. ***Communication with all physicians*** involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care
7. ***Participation in the HHA's QAPI program***
8. Participation in HHA-sponsored in-service training

Deficiency - G704
484.75(b) - Skilled Professional Services

Level 1 Deficiency

- Upon medical record review, 1 of 7 patients did not have services provided that are ordered by the physician as indicated in the plan of care. On the recertification plan of care the SN frequency was 1w2, 2w3, 1w4, the nurse did not make any visits the first week 1, and did 2 visits during the 2nd week.
- Upon medical record review, 4 of 17 did not show evidence that skilled professionals prepared clinical and progress notes and provided services that were ordered by the physician as indicated in the plan of care.
  - POC included SN to perform diabetic nail care monthly, but no diabetic nail care had been performed or discussed by the due date.

Deficiency G704
484.75(b) Skilled Professional Services
(continued)

- POC included the SN to instruct the patient about a low sodium diet, and to weigh daily and document on a calendar. There was no SN clinical documentation that these instructions were provided, and no weights were documented.
- SN note -patient on a NAS diet; POC - patient's diet regular; med planner was not filled as ordered on the plan of care.
- POC- instruct patient to weigh self daily & document in a diary. No instruction or weights were documented in any visit note.

Deficiency G704
484.75(b) Skilled Professional Services
(continued)

Upon medical record review, 8 of 17 did not have evidence in the patient record that skilled professionals assume responsibility for preparing clinical and progress notes and providing care as ordered by the physician as indicated in the plan of care.

- SN did not document procedure utilized for wound vac change.
- SN did not document procedure utilized for PICC line dressing change.
- SN notes are incomplete.
- PT was ordered on xx/xx/xx. No evidence of a visit made.
- SN documented labs drawn -no detail what labs and procedure for lab draw.
- SN visit note states "PICC de-accessed, cleansed using sterile technique per orders. Re-accessed and dressing placed." No order was in record.

Deficiency G720
484.75(b)(8)
Participate in the HHA's QAPI Program

- Agency cannot demonstrate an agency wide program. There are individual clinical audits done each quarter. There is no compilation, threshold, action plan.
- Agency does not utilize quality indicators for objective monitoring of problems identified by the agency.
- Agency is not utilizing data driven results in the QAPI program. CASPER OASIS outcome reports are printed and put into a binder with no identification of what the agency identifies to be a part of the QAPI program.
- Agency staff cannot state what the Agency is working on in the QAPI program.

Plan of Correction-
Ties to QAPI
Skilled Professional Services - Communication with Physician

- **Education-** One-on-one in-service will be provided to affected staff and a staff meeting will be conducted for clinical staff who are responsible for completing the pain assessment to include all elements that need to be present in pain assessment and physician notification for pain.
- **QAPI coordinator** will review 100% of pain assessments for 4 weeks to ensure that the pain assessment is being completed accurately & physician notification has occurred when applicable. Threshold -100%. Once threshold is met, will continue to audit 25% of the pain assessments for accuracy quarterly.

Clinical Records
Deficiency G716
§484.75(b)(6) -Clinical Notes

Level 1 Deficiency

- Upon patient record review, 1 out of 18 records did not show evidence that skilled professionals assume responsibility for preparing clinical notes.
- The left arm PICC was not identified by type (valved versus non-valved, or make such as Bard, Navilyst, Etcetera). The external catheter length, number of lumens, and baseline arm circumference was not performed and then reassessed at least weekly.
- When a new PICC was placed in the right arm, documentation on ___ stated "PICC dressing changed" without stating specifics as noted in the POC, or "per agency protocol".
- The initial assessment ___visit did not include the type and make of PICC, the external catheter length, number of lumens, and baseline arm circumference.
- Documentation on ___stated "dressing changed per orders". SN note does not include the needle type, length, or size and states "de-accessed, cleansed using sterile technique per orders. Re-accessed and dressing placed".

§484.80 – Home Health Aide Services
Deficiency G774
Standard - (d) - In-service Training

Level 2 Deficiency

A home health aide must receive at least 12 hours of in-service training during each 12 month period.

- **Deficiency** Upon aide personnel record review, 2 of 2 did not show evidence of a minimum 12 hours of aide in-service/continuing education during each 12 month period.

❖ **Plan of Correction-** Implement process in which all aides have in service tracking separate from HR file so that these are working documents. Check all aides in service tracking sheets quarterly and schedule in service if aides do not have minimum of 3 hours per quarter.

§484.80(g)(1)
Deficiency G798
Home Health Aide Assignments and Duties

Level 1 Deficiency

Home health aides are assigned to a specific pt by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, PT, OT, SLP).

A home health aide provides services that are:

(i) Ordered by the physician;
(ii) Included in the plan of care;
(iii) Permitted to be performed under state law; and
(iv) Consistent with the home health aide training.

§484.80(g)(1)
Deficiency G798
Home Health Aide Assignments and Duties

- Upon record review, 2 of 3 did not show evidence of thorough written patient care instructions for the Home Health Aide- required placement of a cast for a fractured vertebrae following her bath from the home health aide The aide care plan did not include instructions for this required cast placement, as was evidenced during a surveyor home visit. Patient has been consistently receiving aide services, but the aide care plan was last updated at SOC 8 weeks prior.
- There was no evidence of a competency given by RN to the Aide for this procedure. (crosses over to other aide standards)
- There was no order for this procedure by the physician. (crosses over to other standards)

Deficiency- 484.80(g)(3)
Home Health Aide Service
Services Provided by HH Aide

- Upon medical record review, 2 of 2 did not have evidence Home Health Aide provides services that are ordered by a physician, included in the plan of care, permitted to be performed under state law and, consistent with the home health aide training.
- All aide visits include the completion of: Assist with Transfer, Assist with Medications, Make Breakfast or light meal and Small load of laundry, which are not assigned tasks.

§484.80(h)(4)
Deficiency G818
Supervision of Home Health Aides

(**4) HH Aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to the following elements:**

(i) Following the patient's plan of care for completing of tasks assigned to an aide by RN or other appropriate skilled professional

(ii) Maintaining an open communication process with the patient, representative (if any), caregivers and family

(iii) Demonstrating competency with assigned tasks

(iv) complying with infection prevention and control policies and procedures

(v) reporting changes in the patient's condition

(vi) honoring patient rights

All elements in paragraph (h)(4) need to be accounted for in each and every supervisory visit.

§ 484.80(h)(4)
Deficiency-G818
Home Health Aide Services – HH Aide Supervision Elements

- Upon medical record review, 1 of 4 patients receiving home health aide services there was no evidence of ensuring aide followed the patient's plan of care for completion of tasks assigned to a them by the Registered Nurse; on every visit the aide marked 3 or more tasks N/A or No.
- The following elements were not in evidence for all aide supervisory visits in 4 of 4 records receiving aide services:
- Ensuring open communication with patient/family
- Ensuring Aide honored patient rights
- Ensuring Aide followed infection control and prevention policy and procedure.
- Ensuring Aide report changes in patient's condition

Aide Services Key Points

- Although Aides do not have to be on site for Supervisory patient visits every 14 days, ensure the RN or therapist is talking to Aide to review the assignment sheet/ care plan, as well as all elements in the supervisory visit. In this manner, the Aide assignment sheet can be updated at all times.
- Ensure Aides understand that they *Must do All tasks* on the Aide Assignment sheet and *CANNOT DO anything Not* on the Assignment sheet. Ex: Aide to contact RN if Anything the patient/ caregiver is requesting task is not on assignment sheet
- Educate *all* Aides on reporting all changes in patient condition to the RN immediately and documenting it.

Aide Services
Key Points

- When completing the Aide Assignment sheet, ensure that all tasks are clearly explained, and are specific , i.e. no PRN's or per patient request, as aides cannot have discretion.
- Be sure that Aides assigned to patients are competencied in all tasks assigned. Aide competencies should be a working document for clinical managers to view prior to assigning aides.
- QAPI- always good idea to have Quality Indicator on Aide services, as this is so vulnerable to multiple deficiencies which can quickly lead to Condition level!

Emergency Preparedness

Federal Emergency Preparedness
Top Deficiencies

- E-0037 - Emergency Preparedness Training
- E-0006 - Emergency Preparedness Plan Based On All Hazard Risk Assessment
- E-0032 - Communication Plan
- E-0039 - Emergency Preparedness Testing
- E-0009 - Local, State, Tribal Collaboration
- E-0024 - Policies & Procedures / Volunteers & Staffing
- E-0029 - Development Of Communication Plan
- E-0031 - Emergency Officials Contact
- E-0013 - Emergency Preparedness Policy & Procedures
- E-0019 - Inform Emergency Preparedness Officials About Homebound Patients
- E-0034 - Plan For Communicating Needs

Deficiency
E0013 -Policy & Procedure Development

- HHAs must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk assessment and the communication plan.
- The policies and procedures must be reviewed and updated at least annually

- ❖ Must be Agency Specific
- ❖ Update after drills as procedures may be revised from critiques

§ 484.102(b)
Deficiency- E-0024
Policies and Procedures

Polices & Procedures for Staffing & Volunteers -The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

- ❖ Address the use of volunteers specific to your agency. Get ideas from your local command centers for use of volunteers as well. Document all!

§ 484.102(b)
Deficiency- E-0024
Policies and Procedures
(Continued)

- ❖ Address staffing strategies, including the process and role for integration of State & Federally designated health care professionals to address surge needs.
  - ✓ When discussing plan with Emergency mgmt. staff be sure to address staffing & document all.
- ❖ Ensure you have the plan for contacting off duty staff during emergency / staffing shortage.
  - ✓ Then during drills/testing ensure you contact all and document!

§ 484.102(c)
Deficiency E-0029
Development of Communication Plan

HHAs must have a written emergency communication plan that contains how the HHA coordinates patient care within the HHA, across healthcare providers, and with state and local public health departments.

- The communication plan should support coordination of care.
  - ✓ Between your staff, as well as other healthcare providers in your territory (i.e. LTC, Acute care hospital).
- What are alternative communication resources you will use when for example phones are down? Have alternate options!

§ 484.102(c)
Emergency Preparedness Standard - (c) Communication Plan

The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff

(ii) Entities providing services under arrangement

(iii) Patients' physicians

(iv) Volunteers

§484.102(c)
Emergency Preparedness
Standard - (c) Communication Plan

(2) Contact information for the following:

(i) Federal, State, tribal, regional, or local emergency preparedness staff

(ii) Other sources of assistance

(3) Primary and alternate means for communicating with the HHA's staff, Federal, State, tribal, regional, and local emergency management agencies.

(4) A method for sharing information and medical documentation for patients under the HHA's care, as necessary, with other health care providers to maintain the continuity of care.

Deficiency
E-0031
§484.102(c)(2)

Emergency Officials Contact Information

The communication plan must include contact information for the following:

- Federal, State, tribal, regional, and local emergency preparedness staff.
- Other sources of assistance. *This information should be documented as reviewed and updated annually.

Deficiency
E0032 and E0034
Plan for
Communicating Needs

- The HHA must develop & maintain an EP communication plan that includes means of providing information to the authority having jurisdiction about the HHA's needs & ability to provide assistance.

❖ ***This includes communication regarding evacuation assistance for patients!***
  ✓ ***Test this during drills!***

❖ *Ensure your plan addresses communicating with staff*

❖ *Ensure your plan addresses communicating with government or emergency management agencies*

Deficiency E-0009
Collaboration with Local, State, Tribal
§484.102(a)(4)

- Agency Plan must include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials.

Key Points

❖ *Document efforts to contact such officials!*

❖ ***Intent -*** *There should be collaborative planning*

❖ *Many agencies missing this piece!*

Deficiency E-0019
Inform Emergency Preparedness Officials About Homebound Patients
§484.102(b)(2)

- Policies and procedures must address procedures to inform State and local emergency preparedness officials about homebound HHA patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical/ psychiatric condition and home environment

Key Points

- *Again Must have in your plan and do in your testing!*
- *Have good triage system documented not only in patient record but a list to use in emergency*
- *Document all!*

§484.102(d)
Standard - (d) Training and Testing

- The HHA must develop and maintain an emergency preparedness training and testing program that is based on the emergency, risk assessment, policies and procedures, and the communication plan.
- The training and testing program must be reviewed and updated at least annually.

§484.102(d)
Standard - (d) Training and Testing

(1) ***Training Program:*** **The HHA must do all of the following:**

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, **individuals providing services under arrangement**, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness **training at least annually.**

(iii) Maintain **documentation of the training**.

(ii) **Demonstrate staff knowledge of emergency procedures.**

Deficiency E-0037
Emergency Preparedness Training
§484.102(d)(1)

- Staff and Contractors are not receiving training in emergency preparedness
  - ✓ Evidence of in-services and sign in sheets, but not 100% of all staff & contractors
- Staff not knowing the home health agency emergency preparedness procedures
  - ✓ When interviewing staff, they do not know their role in an emergency

Deficiency E-0037
Emergency Preparedness Training
§484.102(d)(1)

- Upon personnel record review, 11 out of 11 records did not show evidence of emergency preparedness training. The xx/xx/17 staff meeting minutes stated "Handouts given on step by step for completion of emergency preparedness profile as far as contact person". The meeting attendance was 24 out of 74 listed staff, contract, and office personnel. No other training documentation was observed.
- There was no evidence of training of the contracted staff.

Deficiency E-0006
Plan Based on All Hazards Risk Assessment
§484.102(a)(1)(2)

- Risk Assessment Not individualized to agency
  - Generic from sources and/or done by Agency system
- Not customized for risks – i.e. hurricane, blizzards, tornado depending
- Strategies not developed to address the specific risks

Example Hazard Vulnerability Table

Emergency Operations Plan - Hazard Vulnerability Table

AGENCY NAME: _____ ANALYSIS FOR SERVICE AREA(S) _____ Year_____

Event	PROBABILITY				RISK					PREPAREDNESS			TOTAL
	High	Med	Low	None	Life Threat	Health & Safety	High	Med	Low	Poor	Fair	Good	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	
NATURAL EVENTS													
Hurricane													
Tornado													

§484.102(d) Standard - (d) Training and Testing

(2) ***Testing:*** **The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:**

(i) Participate in a **full-scale exercise** that is community-based or when a community-based exercise is not accessible, an individual, facility-based.

If the HHA **experiences an actual natural or man-made emergency** that requires activation of the emergency plan, the HHA is **exempt** from engaging in a community-based or individual, facility-based full-scale exercise **for 1 year** following the onset of the actual event.

§484.102(d)
Standard - (d) Training and Testing

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A **second full-scale exercise** that is community-based or individual, facility based.

(B) A **tabletop exercise** that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

§484.102(d)
Standard - (d) Training and Testing

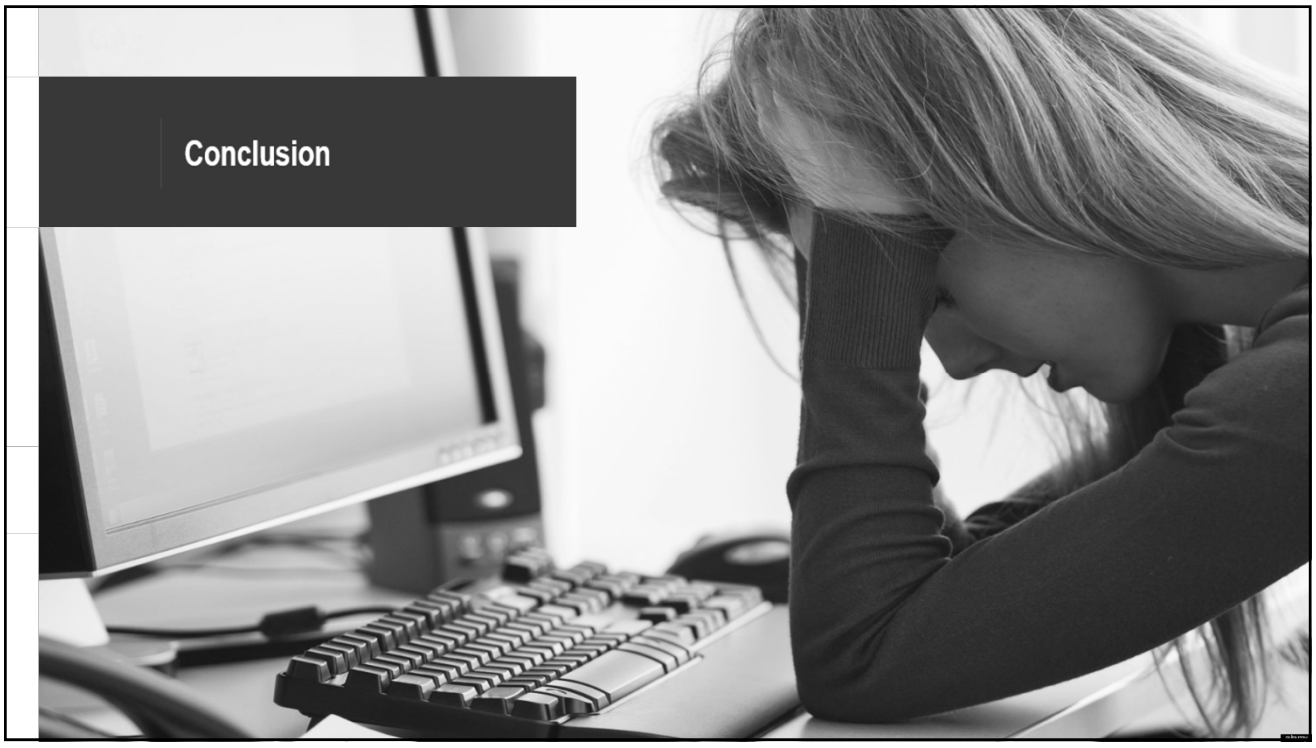
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

Deficiency E-0039

Emergency Preparedness Testing

§484.102(d)(2)

- Contact healthcare coalitions & emergency management agencies to determine if an opportunity exists for community based exercise.
- Ensure that if you include as one test per year a man made or natural event, such as an ice storm, that you go through ALL the steps required in EP, and document all! Often no evidence of this when agency uses a natural event.
- When doing a Table Top Exercise, this must be pre planned and well thought out, using clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. No evidence seen of this.
- Analyze the Tests/Drills! Have an EP task force to review and document. Brainstorm, Improve your Plan!



Conclusion- Tips to Comply With CoPs

- **Frequent Mock Surveys-** by objective qualified person in your agency or an outside qualified entity. Performed the way a Surveyor Will!
  - Determines your vulnerabilities
- **QAPI program can Help You!** Base on high volume, high risk, problem prone areas you find on mock survey, past near misses, past survey deficiencies, CASPER Outcome Reports.
- **Frequent Supervisory Home Visits**
  - Ensure person doing these knows what to look for!

Conclusion- Tips to Comply With CoPs

- **Ongoing Concurrent Clinical Record Reviews**
  - Key to near Real time review allows for: action to be taken for physician notification, improving patient outcomes, preventing emergent care visits, AND having your documentation in compliance!
- **Include 100% of your staff and contractors!** This is KEY to being in compliance! If there is a lack of understanding of the rules, the rules will not be followed!
  - Have Task Forces for Key vulnerable areas – i.e. EP, Pt Rights
  - Have Staff involved in QAPI- rotate so have all staff
  - Utilize your Best Performers to assist with Home Visits, Record Reviews, etc.
  - ***EDUCATE, EDUCATE, EDUCATE!***

Any questions?

THANKS!

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