SURVEY GUIDE

HOME HEALTH AND HOSPICE LICENSURE AND CERTIFICATION

STATE OF WISCONSIN DEPARTMENT OF HEALTH SERVICES

Division of Quality Assurance
Bureau of Health Services

P-63075 (06/2024)

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DQA / BUREAU OF HEALTH SERVICES CONTACT INFORMATION

Central Office – BHS / Acute Care Compliance Section (ACCS)	
DHS / Division of Quality Assurance Bureau of Health Services Acute Care Compliance Section P.O. Box 2969 Madison, WI 53701-2969 **Fed Ex or UPS Deliveries** 1 W. Wilson St., Rm. 450 Madison, WI 53703 **Phone:** 608-266-8481 Send an Email **Fax:** 608-264-9847	**For additional contact information see:** Home Health Agency https://www.dhs.wisconsin.gov/regulations/hha/contacts.htm Hospice https://www.dhs.wisconsin.gov/regulations/hospice/contacts.htm

IMPORTANT LINKS

- Tell us about your survey experience by completing the DQA Post Survey Questionnaire at: https://survey.alchemer.com/s3/7754814/DQA-Post-Survey-Questionnaire
- Stay up-to-date with regulatory changes by signing up for the DQA Listserv at: https://www.dhs.wisconsin.gov/regulations/listserv-signup.htm
- This DQA publication (P-63075) is available at: https://www.dhs.wisconsin.gov/publications/index.htm?search=p-63075&division=All

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I. INTRODUCTION

The Division of Quality Assurance is responsible for conducting unannounced surveys in home health agencies and hospice agencies in Wisconsin to ensure that state licensure and federal Medicare certification requirements are met. The following information has been prepared to serve as a guide to the survey process for licensure and federal certification of home health agencies and hospices.

This survey guide is a general reference for informational purposes. In the event of any conflict between information provided in this guide and the state and federal legal requirements for home health agencies and hospice agencies, please rely on the applicable legal requirements.

II. OVERVIEW OF THE SURVEY PROCESS

The purpose of the survey is to determine whether the entity meets applicable state laws, administrative codes, and federal regulations. If an applicant is requesting licensure as a freestanding **hospice**, the Division will determine if it complies with the physical environment requirements of Wis. Admin. Code ch. DHS 131, Subchapter V. Surveys are conducted by nursing consultants and engineer/architect surveyors employed by the Wisconsin Division of Quality Assurance.

A. Off-Site Survey Preparation

The surveyor reviews the Division's historical file of the entity, profiles, and other applicable information (e.g., waiver/variance reports, OASIS data management, and outcome reports).

The extent of the survey may be increased if the entity has had any of the following:

- Repeat violations from last onsite survey
- Significant complaints, whether or not substantiated, in the past 12 months
- Change in ownership or change in key entity personnel since last survey

B. Entrance Conference

- *Staff Introductions.* The surveyor(s) and other DQA staff will make formal introductions to entity staff. The entity will identify a member of their staff to serve as a liaison/contact person during the survey.
- *Explanation of Visit.* The surveyor(s) will explain the purpose of the visit and the survey process. Time frames for the survey process will also be outlined.
- *Audio/Video Taping.* Any audio or videotaping without the express knowledge and consent of the surveyor(s) impedes the survey process. This could result in termination of the survey.
- *Certification.* The surveyor(s) will explain the federal certification process and how it differs from the state process.
- *Survey Results and Statement of Deficiencies.* The surveyor(s) will explain general ramifications of citations that may be issued to an entity.
- *Request for Information.* The surveyor(s) will request information needed to conduct the survey. The entity will also be asked for a current and accurate list of branches/charting offices associated with the Medicare/Medicaid provider number, as well as a list of Skilled Nursing Facilities (SNFs)/Community Based Residential Facilities (CBRFs)/Assisted Living Facilities (ALFs) and/or group homes where patients reside.

C. Information Gathering

1. **Home Visits.** The surveyor conducts home visits based on a stratified case-mix sample of all current patients. After receiving the patient's oral or written consent, the surveyor observes entity staff implementing the plan of care in the patient's home.
2. **Record Review.** The surveyor reviews a stratified case-mix sample of patient clinical records. Patients selected for home visits are included in the sample. A minimum of two bereavement records and two live discharge records are included in **hospice** surveys.
3. **Personnel Records.** The surveyor reviews a sample of agency personnel records of individuals directly employed or under contract. A sample of nurse aide personnel records is reviewed to ensure that the aides meet the Wisconsin nurse aide directory and competency requirements.
4. **Branch Office/Multiple Location Visits.** Surveyors will visit branch offices or multiple location sites as appropriate to ensure that necessary supervision and quality of care are being provided. A determination will be made whether the location should be separately licensed and Medicare- or Medicaid-certified.
5. **Partial Extended Surveys.** For **home health** agencies, the Division conducts a partial extended survey when there are areas of concern outside of the standard survey components or areas of the standard survey that require a more comprehensive review.
6. **Extended Surveys**
   - For **home health** agencies**,** the Division conducts an extended survey for initial regular licensure determination and when a deficient practice with potential or actual negative outcome is identified during a standard or partial extended survey.
   - Extended surveys will always be conducted for initial regular licensure surveys for a **hospice**.
   - Extended surveys may also be conducted at any time at the discretion of the Division of Quality Assurance. An extended survey for a **hospice** will include a review of all requirements of Wis. Admin. Code ch. DHS 131 and applicable federal Conditions of Participation. An extended

survey for a **home health** agency will include a review of all requirements of Wis. Admin. Code ch. DHS 133 and applicable federal Conditions of Participation. The surveyor will contact management staff of the entity prior to initiating an extended survey.

D. Information Analysis and Compliance Decision Making

The surveyor reviews and analyzes all collected information to determine whether the entity has complied with applicable state rules and federal regulations. The surveyor uses the Medicare State Operations Manual (SOM) as a guide for analysis and decision making. Analysis and decision-making is an ongoing process throughout the survey. The surveyor maintains ongoing, informal communication with the entity's liaison as questions arise. Surveyors will conduct a daily report of findings.

E. Exit Conference

The exit conference is a courtesy and is an informal meeting of the entity and the surveyor at the end of the survey. The surveyor summarizes the preliminary findings, including requirements that have not been met, as well as the facts and examples on which the findings are based. The exit conference also gives the entity the opportunity to discuss the findings and supply additional information. Because of the ongoing dialogue between the surveyor and entity staff during the survey, there should be few instances when the entity is not aware of the surveyor's concerns prior to the exit conference.

The administrator determines which staff, board members, etc., should attend the exit conference. The entity may have legal counsel present, but should give advance notice of this to the surveyor. The exit conference is an informal process and attorneys do not usually attend. Since the survey results are preliminary, surveyors cannot respond to questions raised by legal counsel during exit regarding the findings.

A court reporter may not attend the exit conference. If an entity wishes to audio record or video tape the exit conference, it must first obtain permission from the surveyor. An identical, simultaneous recording must be given to the surveyor at the conclusion of the exit conference. Any eavesdropping, or any audio recording or videotaping without the express knowledge and permission of the surveyor, is considered impeding the survey process. This may result in termination of the survey.

At the conclusion of the exit, the surveyor(s) provide information about how to complete the optional post survey questionnaire, either electronically or in writing.

III. EXPLANATION OF DEFICIENCY STATEMENTS

The surveyor summarizes the survey findings in a final report. If the surveyor determines that the entity is out of compliance with rules, standards, or regulations, the surveyor will document those findings. The findings serve as a basis for the entity to analyze its deficient practices or system failures and develop plans of correction.

Survey findings will be served electronically within 10 working days following the exit conference. For a deemed hospice or HHA, if a Condition of Participation/Coverage is found out of compliance at a CMS authorized survey, the provider will receive the federal survey findings report (CMS-2567) from the Centers for Medicare and Medicaid Services (CMS), Chicago Regional office. Federal survey findings are documented on a CMS form CMS-2567, *Statement of Deficiencies*. State survey findings are documented in a similar format.

A. State Rules and Standards of Non-Compliance

A violation exists when an entity fails to comply with a state statute or administrative rule. The Department of Health Services promulgates and enforces rules and minimum standards necessary to provide safe and adequate care and treatment and to protect the health and safety of the patients and employees of the entity. The Department's authority is derived from the following statutes and

administrative rules.

Wisconsin State Statutes

§ 50.49	Licensing and Regulation of Home Health Agencies
§ 50.90 to 50.98	Hospices
§ 146.40	Instructional Programs for Nurse Aides; Reporting Client Abuse

Wisconsin Administrative Code

ch. DHS 133	Home Health Agencies
ch. DHS 131	Hospices
ch. DHS 12	Caregiver Background Checks
ch. DHS 13	Reporting and Investigating Caregiver Misconduct
ch. DHS 129	Certification of Programs for Training and Testing Nurse Assistants, Home Health Aides, and Hospice Aides

B. Federal Deficiencies

Entities that participate in the federally sponsored Title XVIII (Medicare) and Title XIX (Medicaid) programs are surveyed for compliance with federal regulations. Federal regulations for **home health** agencies are found at 42 CFR 484. Federal regulations for **hospices** are found at 42 CFR 418. Additional federal regulations are also applicable.

A federal deficiency exists when an entity fails to comply with an applicable federal regulation or statute. There are three categories of federal deficiencies, beginning with the most severe:

1. **Noncompliance with Statutory Requirements:** A statutory requirement is created by an Act of Congress. Noncompliance with a statutory requirement may subject an entity to termination of its provider agreement with Medicare and Medicaid.
2. **Noncompliance with Conditions of Participation:** The essential requirements of each of the major divisions of administration and other services are known as Conditions of Participation. A failure to meet a Condition of Participation indicates a breakdown in one of the major health care systems of the entity. An entity's existing provider agreement may be subject to cancellation or termination if a Condition of Participation is not met.
3. **Noncompliance with Standards:** A standard is a major subdivision of the requirements in the Conditions of Participation. Noncompliance with a standard may be so serious that it causes non-compliance with the Condition of Participation. Beginning at the Standard level, deficiencies under the federal regulations require an entity to submit a plan of correction to the Department for approval.

IV. PLAN OF CORRECTION

If, after receiving a Statement of Deficiencies (SOD), entity staff has questions regarding the survey findings, they may consult informally with the surveyor's supervisor to discuss compliance issues.

A plan to correct violations or deficiencies found by the Division should be written electronically on the Plan of Correction form (which is sent with the SOD when issued) and submitted by e-mail to the lead surveyor, or to CMS if directed to do so, no later than 10 calendar days from receipt of the SOD. An authorized representative of the entity should sign and date the first page of the Statement of Deficiencies and return it with the plan of correction.

A. Content

To be considered complete, each plan of correction should include the following:

- What the entity will do to correct the deficient practice and ensure continued compliance in the future

- How correction will be accomplished and monitored
- Who will implement the plan and monitor future compliance
- When the correction(s) will be completed

B. Correction of State Violations

An entity that violates state requirements is requested to submit a plan to correct the violations (plan of correction). A **home health** agency that does not participate in the Medicare or Medicaid programs shall submit a plan of correction within 10 **working** days following receipt of the Statement of Deficiencies for state violations.

A **hospice** that does not participate in the Medicare or Medicaid programs shall submit a plan of correction within 10 **calendar** days of receipt of a Statement of Deficiencies for state violations.

If the entity does not submit an acceptable plan of correction for state violations, the Division may impose a plan of correction on the entity. The Division may revoke the entity's license for a substantial failure to comply with state statutes or rules.

C. Correction of Federal Deficiencies

A federally certified home health agency or hospice must submit a plan of correction for all federal deficiencies within 10 **calendar** days following receipt of a Statement of Deficiencies in order to retain certification in the Medicare or Medicaid programs.

Federal plans of correction that do not meet content standards will be rejected. In such cases, the Division will identify why the plan of correction was not acceptable. The lead surveyor will contact the home health agency or hospice by e-mail and request that a revised plan be submitted.

Failure to submit an acceptable plan of correction within **10 calendar days** of receipt of a Statement of Deficiencies for federal requirements may result in termination of the entity's Medicare or Medicaid provider agreement.

D. Time Period for Correction

Correction should be accomplished within 60 calendar days of the exit conference or sooner. Serious deficiencies or violations require a correction date of 45 calendar days or less. If the completion date extends beyond 60 calendar days, the plan of correction must include benchmark dates to specify when correction stages will be completed. The date for correction must be clearly shown in the appropriate column on the plan of correction form.

An entity that cannot correct a deficiency by the established completion date may request an extension by contacting the surveyor involved. The surveyor and one of the Division's Bureau of Health Services Section Managers will consult with the CMS Chicago office to determine whether the correction time is reasonable and will notify the entity of its decision.

E. Verification of Correction

The Division of Quality Assurance may verify correction of all state and federal deficiencies after the established completion dates have passed through an unannounced surveyor onsite visit, or, when appropriate, through desk review. The surveyor determines which deficiencies can be corrected by desk review with submission of facility documents.

The results of the verification visit survey will be provided to the entity through issuance of a Statement of Deficiencies with the verification findings.

F. Failure to Correct Deficiencies

An entity that participates in the Medicare or Medicaid programs is subject to termination of certification when certain criteria are not met; e.g., if conditions of participation are not corrected within 45 calendar days or less from the day the entity receives the Statement of Deficiencies. If an entity is

unable to meet federal requirements, the Division documents the non-compliance and may initiate termination of federal certification.

Failure to correct a state violation by the date specified in the plan of correction may result in license revocation or conditions being placed on the entity's license.

V. APPEALS

The following information is for general purposes only. An entity should refer to the applicable legal requirements in effect at the time it receives notice of a Department or federal action that may be subject to appeal.

A. Informal Dispute Resolution (IDR) for Medicare-certified Home Health Agencies

When there is a Condition of Participation out of compliance, the home health agency administration may request an IDR. An independent review organization uses a systematic review process and a decision algorithm to arrive at a determination to withdraw citations, keep citations as written, or modify citations.

More information about IDR is contained in DQA publication P-01857, *Informal Dispute Resolution (IDR) Process for Medicare-certified Home Health Agencies (HHA),* available at this link: Informal Dispute Resolution (IDR) for Medicare-Certified Home Health Agencies, P (wisconsin.gov).

B. State Appeals

Home Health Agencies

Home health agencies may contest decisions or actions of the Department as specified in section DHS 133.03(8), Wis. Admin. Code. A written request for a hearing, including a copy of the notice of action that is being contested, must be sent to:

Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The request for a hearing must be made within 10 calendar days of receipt of the notice of the contested action.

Hospices

Hospices may contest decisions or actions of the Department as specified in section DHS 131.14(11), Wis. Admin. Code, and sections 50.93(4) and 50.98(4) of the Wisconsin State Statutes. A written request for a hearing, including a copy of the notice of action that is being contested, must be sent to:

Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The request for a hearing must be made within 10 calendar days of receipt of the notice of the contested action.

C. Federal Appeals

Information about federal appeals is provided in the CMS certification letter sent to the entity with the Statement of Deficiencies.

VI. COMPLAINTS

A. Entity Patient Complaints

The Division of Quality Assurance responds to two types of health care complaints — entity practices

and caregiver misconduct. The Division's Bureau of Health Services receives complaints and conducts complaint surveys for entity practice concerns such as inappropriate or inadequate health care, lack of entity staff training, understaffing, poor quality care, etc.

Please see https://www.dhs.wisconsin.gov/guide/complaints.htm for more information on filing a complaint.

A patient may use any of the following methods for submitting a home health or hospice agency complaint.

- By **online form:**
  File a complaint online by completing the Complaint Intake Survey, F-00607(link is external)
- By **telephone:**
  Home Health / Hospice Hotline (toll free) 1-800-642-6552
  Home Health / Hospice Hotline (Madison) 608-267-1441
- By submitting a **letter** to:
  DQA / Office of Caregiver Quality
  Caregiver Intake Unit
  P.O. Box 2969
  Madison, WI 53701-2969
- By submitting a Form, accessible at https://www.dhs.wisconsin.gov/forms/index.htm, to DQA:
  - F-62069 Home Health Agency Complaint Report
  - F-62287 Hospice Complaint

B. Caregiver Misconduct

Complaints about caregiver misconduct relate to specific incidents between a caregiver and patient, such as:

- Abuse — hitting, slapping, verbal, or sexual actions
- Neglect — intentional carelessness or disregard of policy or care plan
- Misappropriation — theft, using property without consent (i.e., telephone or credit cards)

All entities regulated by the Division of Quality Assurance must immediately protect patients from subsequent incidents of caregiver misconduct, investigate all allegations of caregiver misconduct, and determine whether or not the incident must be reported to DQA.

Please see https://www.dhs.wisconsin.gov/caregiver/complaints.htm for information on investigating and reporting caregiver misconduct.

To report caregiver misconduct see DQA Form F-62447 — Misconduct Incident Report.

The Misconduct Incident Reporting (MIR) system is a secure, web-based system for entities to submit the Misconduct Incident Report, F-62447 form.

Entities must create and register an account to access the MIR system. It may take up to three business days to process a registration. Refer to DQA Misconduct Incident Reporting (MIR) System: How to Sign Up, P-02312 (PDF) for instructions.

If the MIR system cannot be accessed, reports will be accepted via postal mail, fax, or email at:

Department of Health Services
Division of Quality Assurance
Office of Caregiver Quality
PO Box 2969
Madison, WI 53701-2969
Fax: 608-264-6340
Email: DHSCaregiverIntake@wi.gov