

	Department of Health Services, State of Wisconsin	
Federal Tags Cited	Regulation Language	Number of Cites
484.12(c) Compliance w/accepted professional standards	The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.	7
484.18(a) Plan of Care (content of PoC)	The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.	5
484.14(g) Coordination of Patient Services (summary report schedule)	A written summary report for each patient is sent to the attending physician at least every 60 days.	4
484.18 Acceptance of Patients, PoC, Medical Supervision (periodic review)	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	3
484.48 Clinical Records (discharge summary)	The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge.	3
484.55(c) Drug Regimen Review	The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.	3
484.14(g) Coordination of Patient Services (recording patient care)	The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.	2
484.18(c) Conformance with Physician Orders (drugs and treatments)	Drugs and treatments are administered by agency staff only as ordered by the physician.	2
484.30 Skilled Nursing Services (compliance w. plan of care)	The HHA furnishes skilled nursing services in accordance with the plan of care.	2
484.36(d)(2) Supervision	The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.	2
484.10(c)(2) Right to be Informed and to Participate	The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.	1
484.18(b) Periodic Review of Plan of Care (triggering circumstances)	The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode.	1
484.30(a) Duties of the Registered Nurse (records and shares progress updates)	The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.	1
484.36(d)(3) Supervision	If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.	1
484.48 Clinical Records (contents of record)	A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.	1
484.48(a) Retention of Records (transfer w. patient)	If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient.	1
Total Federal Tags Cited for Quarter		39

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State Tags Cited	Code Language	Number of Cites
133.20(1) Plan of Care	REQUIREMENT. A plan of care, including physician's or advanced practice nurse prescriber's orders, shall be established for every patient accepted for care and shall be incorporated in the patient's medical record. An initial plan shall be developed within 72 hours of acceptance. The total plan of care shall be developed in consultation with the patient, home health agency staff, contractual providers, and the patient's physician or advanced practice nurse prescriber and shall be signed by the physician or advanced practice nurse prescriber within 20 working days following the patient's admission for care.	7
133.20(2)(a) Plan of Care	CONTENTS OF PLAN. Each plan developed under sub. (1) shall include: (a) Measureable time-specific goals, with benchmark dates for review; and	6
133.21(5)(h) Medical Records	CONTENT. (h) Summaries of reviews of the plan of care; and	4
133.20(4) Plan of Care	ORDERS. Drugs and treatment shall be administered by the agency staff only as ordered by the attending physician or the advanced practice nurse prescriber. The nurse or therapist shall immediately record and sign and date oral orders and obtain the physician's or advanced practice nurse prescriber's countersignature and date within 20 working days.	3
133.21(1) Medical Records	REQUIREMENT. A medical record shall be maintained on each patient and shall be completely and accurately documented, systematically organized and readily accessible to authorized personnel.	3
133.09(3)(b) Discharge Summary	The home health agency shall complete a written discharge summary within 30 calendar days following discharge of a patient. The discharge summary shall include a description of the care provided and the reason for discharge. The home health agency shall place a copy of the discharge summary in the former patient's medical record. Upon request, the home health agency shall provide a copy of the discharge summary to the former patient, the patient's legal representative the attending physician or advanced practice nurse prescriber.	2
131.18(1) Supervisory Visits	If a patient receives skilled nursing care, a registered nurse shall make a supervisory visit to each patient's residence at least every 2 weeks. The visit may be made when the home health aide is present or when the home health aide is absent. If the patient is not receiving skilled nursing care, but is receiving another skilled service, the supervisory visit may be provided by the appropriate therapist providing a skilled service.	2
133.20(3) Plan of Care	REVIEW OF PLAN. The total plan of care shall be reviewed by the attending physician or advanced practice nurse prescriber, and appropriate agency personnel as often as required by the patient's condition, but no less often than every 60 days. The agency shall promptly notify the physician or advanced practice nurse prescriber of any changes in the patient's condition that suggest a need to modify the plan of care.	2
133.21(6) Medical Records	FORM OF ENTRIES. All entries in the medical record shall be legible, permanently recorded, dated and authenticated with the name and title of the person making the entry.	2
133.05(1)(e) Governance	The governing body shall: (e) Provide for a qualified substitute administrator to act in absence of the administrator.	1
133.06(2)(a) Administration	DUTIES OF THE ADMINISTRATOR. The administrator shall: (a) Be knowledgeable about this chapter, and shall take all reasonable steps to ensure compliance of the agency with the requirements of this chapter;	1
133.06(4)(d)1. Administration - Employees - Health	1. Physical health of new employees. Each new employee having direct patient contact shall be certified in writing by a physician, physician assistant or registered nurse as having been screened for tuberculosis, and clinically apparent communicable disease that may be transmitted to a patient during the normal performance of the employee's duties. The screening shall occur within 90 days prior to the employee having direct patient contact.	1
133.06(4)(d)2. Administration - Employees - Health	'Continuing employees'. Each employee having direct patient contact shall be screened for clinically apparent communicable disease by a physician, physician assistant, or registered nurse based on the likelihood of their exposure to a communicable disease, including tuberculosis. The exposure to a communicable disease may have occurred in the community or in another location.	1
133.08(1) Patient Rights	SERVICE APPLICANT. The home health agency shall promptly determine the applicant's suitability for services and, if the applicant is accepted, shall promptly provide services to the individual. If the applicant is found unsuitable for acceptance, the agency shall inform the applicant of other service providers in the area.	1
133.08(2)(d) Patient Rights - Policies	Each patient receiving care from the agency shall have the following rights: (d) To be fully informed of one's own health condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of the home health services, including referral to health care institutions or other agencies, and to refuse to participate in experimental research;	1
133.08(2)(g) Patient Rights - Policies	Each patient receiving care from the agency shall have the following rights: (g) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs; and	1

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133.09(2) Service Agreement	SERVICE AGREEMENT. Before care is initiated, the home health agency shall inform the patient, orally and in writing, of the extent to which payment may be expected from other sources, the charges for services that will not be covered by other sources and charges that the individual may have to pay.	1
133.09(3)(a)1. Discharge of Patients	Notice of discharge. 1. A home health agency may not discharge a patient for any reason until the agency has discussed the discharge with the patient or the patient's legal representative and the patient's attending physician or advanced practice nurse prescriber, and has provided written notice to the patient or the patient's legal representative in the timelines specified in this paragraph.	1
133.09(3)(a)5.a. Discharge of Patients	Notice of discharge The home health agency shall include in every written discharge notice to a patient or the patient's legal representative all of the following: a. The reason for discharge.	1
133.09(3)(a)5.b. Discharge of Patients	Notice of discharge The home health agency shall include in every written discharge notice to a patient or the patient's legal representative all of the following: b. A notice of the patient's right to file a complaint with the department and the department's toll - free home health hotline telephone number and the address and telephone number of the department's bureau of quality assurance.	1
133.12 Coordination with Other Providers	The home health agency shall coordinate its services with any other health or social service providers serving the patient.	1
133.14(1) Skilled Nursing Services	PROVISION OF SERVICES. Skilled nursing services shall be provided by or under the supervision of a registered nurse.	1
133.14(2)(a) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (a) Make the initial evaluation visit to the patient;	1
133.14(2)(b) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (b) Regularly reevaluate the patient's needs;	1
133.14(2)(c) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (c) Initiate the plan of care and necessary revisions;	1
133.14(2)(e) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (e) Initiate appropriate preventive and rehabilitative procedures;	1
133.14(2)(g) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (g) Promptly inform the physician or advanced practice nurse prescriber and other personnel participating in the patient's care of changes in the patient's condition and needs;	1
133.17(1) Home Health Aide Services	PROVISION OF SERVICES. When a home health agency provides or arranges for home health aide services, the services shall be given in accordance with the plan of care provided for under s. HSS 133.20, and shall be supervised by a registered nurse or, when appropriate, by a therapist.	1
133.17(3) Home Health Aide Services - Assignments	Home health aides shall be assigned to specific patients by a registered nurse. Written instructions for patient care shall be prepared and updated for the aides at least each 60 days by a registered nurse or appropriate therapist, consistent with the plan of care under s. HSS 133.20. These instructions shall be reviewed by the immediate supervisors with their aides.	1
133.18(2) Supervisory Visits	If home health aide services are provided to a patient who is not receiving skilled nursing care, or physical, occupational or speech-language therapy, the registered nurse shall make a supervisory visit to the patient's residence, when the home health aide is present or when the home health aide is absent, at least every 60 days to observe or assist, to assess relationships, and to determine whether goals are being met and whether home health services continue to be required.	1
133.20(2)(b) Plan of Care	CONTENTS OF PLAN. Each plan developed under sub. (1) shall include: (b) The methods for delivering needed care, and an indication of which professional disciplines are responsible for delivering the care.	1
133.21(4) Medical Records	TRANSFER. If a patient is transferred to another health facility or agency, a copy of the record or abstract shall accompany the patient.	1
133.21(5)(f) Medical Records	CONTENT. (f) Medication list and documentation of patient instructions;	1
133.21(5)(i) Medical Records	CONTENT. (i) Discharge summary, completed within 30 days following discharge.	1
133.06(5)(c) Infection Control Monitoring and Retraining	Monitor adherence to evidence-based standards of practice related to protective measures. When monitoring reveals a failure to follow evidence-based standards of practice, the home health agency shall provide counseling, education or retraining to ensure staff is adequately trained to complete their job responsibilities.	1
TOTAL STATE TAGS CITED PER QUARTER		57
TOTAL ALL TAGS CITED PER QUARTER		96

	Department of Health Services, State of Wisconsin	
	Complaint surveys	5
	Partial Extended	0
	Extended	0
	State licensure only	3
	Federal Initial & Recertification Surveys	14
	Verification Visits	0
	Other	0
	TOTAL SURVEYS PERFORMED:	22