

	Department of Health Services, State of Wisconsin	
Federal Tags Cited	Regulation Language	Number of Cites
484.18 Acceptance of Patients, PoC, Medical Supervision (physician periodic review of care plan)	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	5
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
484.18(a) Plan of Care (contents)	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.	2
484.30(a) Duties of the Registered Nurse (RN initiates plan of care)	The registered nurse initiates the plan of care and necessary revisions.	2
484.36(b)(20(ii) Competency Evaluation and In-Service Training	The HHA must complete a performance review of each home health aide no less frequently than every 12 months.	2
484.10(b)(5) Exercise of Rights and Respect for Property	The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.	1
484.12(c) Compliance w. Accepted Professional Standard	The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.	1
484.14(c) Administrator	The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.	1
484.30(a) Duties of the Registered Nurse (regular patient evaluation)	The registered nurse regularly re-evaluates the patients nursing needs.	1
484.30(a) Duties of the Registered Nurse (maintains clinical notes)	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
484.32 Therapy Services	The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)	1
484.36(c)(1) Assignment & Duties of Home Health Aide	Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.	1
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.	1
484.55(b)(1) Completion of the Comprehensive Assessment	The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.	1
484.55(e) Incorporation of OASIS Data Items	The OASIS data items determined by the Secretary must be incorporated into the HHA's own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.	1
Total Federal Tags Cited for Quarter		24

	Department of Health Services, State of Wisconsin	
State Tags Cited	Code Language	Number of Cites
133.20(2)(a) Plan of Care (measurable goals)	CONTENTS OF PLAN. Each plan developed under sub. (1) shall include: (a) Measureable time-specific goals, with benchmark dates for review; and	4
133.06(4)(c) Administration - Employees	EVALUATION. Every employe shall be evaluated periodically for quality of performance and adherence to the agency's policies and this chapter, in accordance with the written plan of evaluation under sub. (3)(b).	3
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
133.09(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.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
133.14(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)(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
133.15(1) Therapy Services	PROVISION OF SERVICES. Physical therapy, occupational therapy, speech therapy, and other therapy services provided directly by the home health agency or arranged for under s. HSS 133.19, shall be given in accordance with the plan of care developed under s. HSS 133.20. Individuals providing these services shall perform the duties under s. HSS 133.14(2)(a),(c),(f),(h) and (i).	1
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.	1
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.	1
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.	1
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.	1
133.21(2) Medical Records	SECURITY. Medical record information shall be safeguarded against loss, destruction or unauthorized use. Written procedures shall be established to control use and removal of records and to identify conditions for release of information.	1
TOTAL STATE TAGS CITED PER QUARTER		19
TOTAL ALL TAGS CITED PER QUARTER		43

	Department of Health Services, State of Wisconsin	
	Complaint surveys	1
	Partial Extended	0
	Extended	0
	State licensure only	0
	Federal Initial & Recertification Surveys	11
	Verification Visits	2
	Other	0
	TOTAL SURVEYS PERFORMED:	14