

	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.	4
484.18 Acceptance of Patients, PoC, Med Supervisor (plan of care established and reviewed)	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	3
484.18(a) Plan of Care	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.	3
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.	2
484.10(c)(1) Right to be Informed and Participate	The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made.	1
484.10(c)(2) Right to be Informed and Participate	The patient has the right to participate in the planning of the care. The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.	1
484.14(g) Coordination of Patient Services	All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.	1
484.18(c) Conformance with Physician Orders	Drugs and treatments are administered by agency staff only as ordered by the physician.	1
484.30 Skilled Nursing Services	The HHA furnishes skilled nursing services in accordance with the plan of care.	1
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.	1
484.48 Clinical Records	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(b) Protection of Records	Clinical record information is safeguarded against loss or unauthorized use.	1
484.55(c) Drug Review Regimen	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.	1
<b>Total Federal Tags Cited for Quarter</b>		<b>21</b>

State Tags Cited	Code Language	Number of Cites
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	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
DHS 13.05(3)(a) ENTITY ALLEGATION REPORTING REQUIREMENTS	Entity's duty to report to the department. Except as provided under pars. (b) and (c), an entity shall report to the department any allegation of an act, omission or course of conduct described in this chapter as client abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity if the person is under the control of the entity. The entity shall submit its report on a form provided by the department within 7 calendar days from the date the entity knew or should have known about the misconduct. The report shall contain whatever information the department requires.	2
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)(h) Patient Rights - Policies	Each patient receiving care from the agency shall have the following rights: (h) To be taught, and have the family taught, the treatment required, so that the patient can, to the extent possible, help himself or herself, and the family or other party designated by the patient can understand and help the patient.	1
133.10(1) Required Services	REQUIRED SERVICES. The home health agency shall directly provide at least part-time or intermittent nursing services and provide or arrange for home health aide services.	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(5) Skilled Nursing Services	COORDINATION OF SERVICES. A registered nurse shall maintain overall responsibility for coordinating services provided to the patient by the agency.	1
133.18(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.	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
<b>TOTAL STATE TAGS CITED PER QUARTER</b>		<b>17</b>
<b>TOTAL ALL TAGS CITED PER QUARTER</b>		<b>38</b>

	Complaint surveys	7
	Partial Extended	0
	Extended	0
	State licensure only	1
	Federal Initial & Recertification Surveys	8
	Verification Visits	1
	Other	0
<b>TOTAL SURVEYS PERFORMED:</b>		<b>17</b>