

	Department of Health Services, State of Wisconsin	
Federal Tags Cited	Regulation Language	Number of Cites
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.	5
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.	3
484.18 Acceptance of Patients, PoC, Medical Supervision	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	2
484.55(a)(1) Initial Assessment Visit	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.	2
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.	2
484.14(c) Administrator (other qualified person)	A qualified person is authorized in writing to act in the absence of the administrator.	1
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.	1
484.18 Acceptance of Patients, PoC, Med Supervisor	Condition of participation	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
484.18(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 (compliance w. plan of care)	The HHA furnishes skilled nursing services in accordance with the plan of care.	1
484.30(a) Duties of the Registered Nurse (initiate preventative/rehabilitative care)	The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.	1
484.48 Clinical Records (elements 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
484.55(d)(1) Update of the Comprehensive Assessment	The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.	1
Total Federal Tags Cited for Quarter		23

	Department of Health Services, State of Wisconsin	
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.	4
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
133.05(1)(e) GOVERNANCE	The governing body shall: (e) Provide for a qualified substitute administrator to act in absence of the administrator.	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
133.20(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(5)(h) Medical Records	CONTENT. (h) Summaries of reviews of the plan of care; and	1
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.	1
TOTAL STATE TAGS CITED PER QUARTER		14
TOTAL ALL TAGS CITED PER QUARTER		37
	Complaint surveys	4
	Partial Extended	0
	Extended	0
	State licensure only	0
	Federal Initial & Recertification Surveys	9
	Verification Visits	1
	Other	0
TOTAL SURVEYS PERFORMED:		14