

**HHA HEALTH SURVEY STATISTICS**  
**April through June 2012**

	<b>Department of Health Services, State of Wisconsin</b>	
<b>Federal Tags Cited</b>	<b>Regulation Language</b>	<b>Number of Cites</b>
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.	8
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.	6
484.18(c) Conformance with Physician's Orders	Drugs and treatments are administered by agency staff only as ordered by the physician.	6
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.	4
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	3
484.48(b) Protection of Records	Clinical record information is safeguarded against loss or unauthorized use.	3
484.14(f) Personnel Hourly/Per Visit Contract	If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: (1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.	2
484.14(g) Coordination of Patient Services (record of case conferences)	The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.	2
484.30(a) Duties of the Registered Nurse (monitors patient)	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.	2
484.36(d) 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 Patient Rights	The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights	1
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(e)(1) Patient Liability for Payment	The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient.	1
484.14(g) Coordination of Patient Services (summary report)	A written summary report for each patient is sent to the attending physician at least every 60 days.	1
484.16 Group of Professional Personnel	The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.	1
484.18 Acceptance of Patient, PoC, Med Super	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	1
484.30(a) Duties of the Registered Nurse (reevaluation)	The registered nurse regularly re-evaluates the patients nursing needs.	1
484.30(a) Duties of the Registered Nurse (specialized services)	The registered nurse furnishes those services requiring substantial and specialized nursing skill.	1
484.30(a) Duties of the Registered Nurse (prevention/rehabilitation)	The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.	1
<b>Total Federal Tags Cited for Quarter</b>		<b>47</b>

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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.	6
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
133.21(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.	4
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.	3
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.	3
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.	2
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.	2
133.05(2)(a) Governance-Professional Advisory Body	PROFESSIONAL ADVISORY BODY. (a) The home health agency shall establish an advisory group of at least one practicing physician and one registered nurse and appropriate representation from other professional disciplines. A majority of the members shall be persons who are neither owners nor employees of the agency.	1
133.05(2)(b)1. Governance-Professional Advisory Body	The advisory group shall: 1. Review annually and make recommendations to the governing body concerning the agency's scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation;	1
133.06(4)(b) Administration - Employees	SCOPE OF DUTIES. No employees may be assigned any duties for which they are not capable, as evidenced by training or possession of a license.	1
133.065(c) Infection Control Monitor 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
133.08(2) Patient Rights - Policies	POLICIES. The home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. Each patient receiving care from the agency shall have all of the following rights:	1
133.08(2)(b) Patient Rights - Policies	Each patient receiving care from the agency shall have the following rights: (b) To be fully informed, prior to or at the time of admission, of services available from the agency and of related charges, including any charges for services for which the patient or a private insurer may be responsible;	1
133.08(3) Patient Rights - Policies	COMPLAINTS. At the same time that the statement of patient rights is distributed under sub. (2), the home health agency shall provide the patient or guardian with a statement, provided by the department, setting forth the right to and procedure for registering complaints with the department.	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
133.14(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)(d) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (d) Provide those services requiring substantial specialized care;	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
133.17(4)(b) Home Health Aide Services-Training	TRAINING OF AIDES - TRAINING. Training, if provided by the agency, shall be directed by a registered nurse. Physicians, nutritionists, physical therapists, medical social workers, and other health personnel shall provide relevant training when pertinent to the duties to be assigned.	1
133.19(1) Services Under Contract	TERMS. A written contract shall be required for health care services purchased on an hourly or per visit basis or by arrangement with another provider.	1
133.19(2) Services Under Contract	QUALIFICATIONS OF CONTRACTORS. All providers of services under contract shall meet the same qualifications required of practioners of the same service under the terms of this chapter.	1

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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(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(5)(h) Medical Records	CONTENT. (h) Summaries of reviews of the plan of care; and	1	
50.065(4)(mc) Complete Background Information Disclosure	If the background information form completed by a person under sub. (6) (am) indicates that the person is not ineligible to be employed or contracted with for a reason specified under par. (b) 1. to 5., an entity may employ or contract with the person for not more than 60 days pending the receipt of the information sought under sub. (2) (b). If the background information form completed by a person under sub. (6) (am) indicates that the person is not ineligible to be permitted to reside at an entity for a reason specified in par. (b) 1. to 5. and if an entity otherwise has no reason to believe that the person is ineligible to be permitted to reside at an entity for any of these reasons, the entity may permit the person to reside at the entity for not more than 60 days pending receipt of information sought under sub. (2) (am). An entity shall provide supervision for a person who is employed or contracted with or permitted to reside as permitted under this paragraph.	1	
50.065(6)(am) Four Year Caregiver Background Requirement	Every 4 years an entity shall require its caregivers and nonclient residents to complete a background information form that is provided to the entity by the Department.	1	
<b>TOTAL STATE TAGS CITED PER QUARTER</b>		<b>44</b>	
<b>TOTAL ALL TAGS CITED PER QUARTER</b>		<b>91</b>	

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	Department of Health Services, State of Wisconsin	
	Complaint surveys	4
	Partial Extended	0
	Extended	0
	State licensure only	0
	Federal Initial & Recertification Surveys	11
	Verification Visits	3
	Other	0
<b>TOTAL SURVEYS PERFORMED:</b>		<b>18</b>