

	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.	6
484.30(a) Duties of the Registered Nurse (prevention/rehabilitation)	The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.	5
484.30(a) Duties of the Registered Nurse (care coordination)	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.	4
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
484.18(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
484.30 Skilled Nursing Services (plan of care)	The HHA furnishes skilled nursing services in accordance with the plan of care.	3
484.48 Clinical Records	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.	3
484.10(e)(1(i-iii) Patient Liability for Payment	Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay.	2
484.30 Skilled Nursing Services	Condition	2
484.30(a) Duties of the Registered Nurse (reevaluation)	The registered nurse regularly re-evaluates the patients nursing needs.	2
484.30(a) Duties of the Registered Nurse (counseling)	The registered nurse counsels the patient and family in meeting nursing and related needs.	2

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484.20(a) Encoding Oasis Data	The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set.	2
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.	2
484.10 Patient Rights	Condition	1
484.10(f) Home Health Hotline	The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.	1
484.18 Acceptance of Patient, PoC, Med Super	Condition	1
484.19(c) Conformance with Physician Orders	Drugs and treatments are administered by agency staff only as ordered by the physician.	1
484.30(a) Duties of the Registered Nurse (plan of care)	The registered nurse initiates the plan of care and necessary revisions.	1
484.36(d)(1) Supervision	If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist.	1
484.20 Reporting OASIS Information	HHAs must electronically report all OASIS data collected in accordance with §484.55	1
484.20(b) Accuracy of Encoded OASIS Data	The encoded OASIS data must accurately reflect the patient's status at the time of assessment.	1
484.20(c)1 Transmittal of OASIS Data	The encoded OASIS data must accurately reflect the patient's status at the time of assessment.	1

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484.55 Comprehensive Assessment of Patient	Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary	1
484.55(a)(1) Initial Assessment Visit (time limits)	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.	1
Total Federal Tags Cited for Quarter		51

State Tags Cited	Code Language	Number of Cites
133.14(2)(e) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (e) Initiate appropriate preventive and rehabilitative procedures;	5
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.	4
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.	3
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.	2
133.14(2)(b) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (b) Regularly reevaluate the patient's needs;	2
133.14(2)(h) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (h) Arrange for counseling the patient and family in meeting related needs;	2
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	2
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.	2
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(30)(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)(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.	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(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)(j) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (j) Supervise and teach other personnel.	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(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
133.21(5)(f) Medical Records	CONTENT. (f) Medication list and documentation of patient instructions;	1
TOTAL STATE TAGS CITED PER QUARTER		31
TOTAL ALL TAGS CITED PER QUARTER		82
	Complaint surveys	4
	Partial Extended	0
	Extended	0
	State licensure only	3
	Federal Initial & Recertification Surveys	8
	Verification Visits	3
	Other	0
TOTAL SURVEYS PERFORMED:		18