

	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
484.18(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	5
484.18(c) Conformance with Physician's Orders	Drugs and treatments are administered by agency staff only as ordered by the physician.	3
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	3
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.	2
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.	2
484.10(c)(2) Right to be Informed and to 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 (plan of care)	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 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

Federal Tags Cited	Regulation Language	Number of Cites
484.18(b) Periodic Review of Plan of Care	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
484.30 Skilled Nursing Services	The HHA furnishes skilled nursing services in accordance with the plan of care.	1
484.30(a) Duties of the Registered Nurse (prevention/rehabilitation)	The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.	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		28

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	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.	5
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
133.21(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(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
133.12 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)(e) Skilled Nursing Services	DUTIES OF THE REGISTERED NURSE. The registered nurse shall: (e) Initiate appropriate preventive and rehabilitative procedures;	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
50.065(2)(b)intro ENTITY BACKGROUND CHECK REQUIREMENTS	Every entity shall obtain all of the following with respect to a caregiver of the entity: 1. A criminal history search from the records maintained by the department of justice. 2. Information that is contained in the registry under s. 146.40 (4g) regarding any findings against a person. 3. Information maintained by the department of regulation and licensing regarding the status of the person's credentials, if applicable. 4. Information maintained by the department regarding any substantiated reports of child abuse or neglect against the person. 5. Information maintained by the department under this section regarding any denial to the person of a license, certification, certificate of approval or registration or a continuation of a license, certification, certificate of approval or registration to operate an entity for a reason specified in par. sub. (4m) (2) 1. to 5. and regarding any denial to the person of employment at, a contract with or permission to reside at an entity for a reason specified in sub. (4m) (b) 1. to 5.	1
TOTAL STATE TAGS CITED PER QUARTER		21

TOTAL ALL TAGS CITED PER QUARTER		49
	Complaint surveys	6
	Partial Extended	0
	Extended	0
	State licensure only	1
	Federal Initial & Recertification Surveys	17
	Verification Visits	0
	Other	0
TOTAL SURVEYS PERFORMED:		24