Survey Readiness:
Don't Leave Your HH Survey to Luck!

A STEP-BY-STEP FOR THE ENTIRE PROCESS TO SUCCESS!

2026

PROVIDER INSIGHTS

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Take-Aways from this Session

PROVIDER INSIGHTS

- ❑Tools for survey preparation and how to create a survey manual
- ❑Learn how to do a self-assessment
- ❑Know the top 10 national citations and how to avoid them
- ❑Focus on Emergency Preparedness and Infection Control
- ❑Several tools to use in your preparation process

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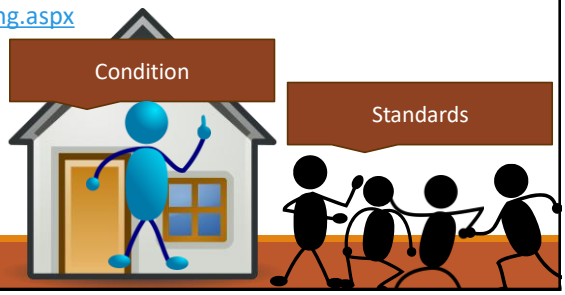
State Operation Manual (SOM)

- First update in FOUR years released on 3/15/24 "Preliminary"
  - Ooops! **And, then CMS released the FINAL on 4/12/24!** https://www.cms.gov/files/document/r219soma.pdf
- Complete overhaul to the SOM surveyor instructions
- Still waiting for inclusion of new COP- Acceptance of Patients (1/1/25) to give the surveyors (and US) the interpretive guidelines
- On-line training will be available at: https://qsep.cms.gov/ProvidersAndOthers/publictraining.aspx

CONDITION: The household name-

Standards: Children- make up the household



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State Operations Manual
Appendix B - Guidance to Surveyors: Home Health Agencies

Table of Contents
(Rev. 219; Issued: 04-12-24)

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Survey protocols and guidance

- Provides more structure and clearer instructions for survey
- **Level 1 tags all assessed during standard survey**
  - If failing any Level one is a "partial extended survey",
  - If a level one deficiency, then ALL standards associated with the COP where the non-compliance was found
    - **Discontinued the "Level 2 tags"**
    - **Discontinued the full widespread "Partial extended survey", now just focused on standards within the SAME Condition**
  - If failing at one Condition- then a full "extended survey" will be completed
- Includes in several CoPs and in Survey protocol guidance, CMS provides this guidance to surveyors to determine level of non-compliance:
  - "The manner and degree of noncompliance identified in relation to the standard level tags for xxxxx may result in substantial noncompliance with this CoP, requiring citation at the condition level"

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Nine Level ONE COPs Out of 10 Patient Care Conditions and five Administrative COPs

Added 3 E-Tags to Standard Survey

www.cms.gov/files/document/qso-21-15-all.pdf

Plan, Policies reviewed q 2 yr, Training/testing q 2 yr

§484.50 Patient Rights	*G412, G414, G416, G418, G422, G428, G430, G432, G434, G436, G438, G442, G444, G448, G454, G464, G478, G484, G486, G488, G490*
§484.55 Comprehensive Assessment of Patients	*G514, G516, G520, G528, G530, G532, G534, G536, G544, G546*
§484.60 Care planning, coordination of services, and quality of care.	*G572, G574, G576, G580, G582, G584, G588, G590, G592, G596, G598, G602, G604, G606, G608, G610, G612, G614, G616, G618, G620, G622*
§484.70 Infection prevention and control	*G682, G686*
§484.75 Skilled Professional Services	*G704, G706, G708, G710, G712, G714, G716, G718, G724, G726, G728, G730*
§484.80 Home Health Aide Services	*G768, G772, G798, G800, G802, G804, G808, G810, G812, G816, G818*
*§484.102 Emergency Preparedness *See Appendix Z for details*	*E-0004, E-0013, E-0036*
§484.105 Organization and Administration of Services	*G982, G984*
§484.110 Clinical Records	*G1012, G1014, G1016, G1018, G1022, G1024, G1028*

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New Structure

- • Task 1 - Pre-Survey Preparation
- • Task 2 - Entrance Interview
- • Task 3 – Survey Sample Selection** (NEW!)
- • Task 4 - Information Gathering
- • Task 5 - Preliminary Decision Making and Analysis of Findings
- • Task 6 - Exit Conference
- • Task 7 – Post-Survey Activities

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More direction on sample patients

- CMS provided the surveyors in writing the types of patients that should be reviewed- similar to what we typically see during survey
  - Infusion therapies
  - Wound care, wound VAC
  - Pediatric care
  - Anticoagulant therapy
  - Diabetes management
  - CHF
  - Enteral/parenteral nutrition
  - Trach care
  - Therapy modalities such as ultrasound

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Prepping for Survey?

Where and HOW do _You even START?!

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How to Organize your Survey Prep

EVERYONE is involved in Prep OVER Panic!

Cuecards or Cheatsheets for EVERYONE!

- Receptionist/Office personnel
  - Cue to ask for ID or business cards from surveyors
  - Who to alert
  - Where to seat the surveyors (Accessible, but not in middle of the work!)
  - Orient to "must haves" in office- where the restrooms are, water, etc.
- IT Designee
  - How to get passwords/set up for survey access in EMR
  - How to run the survey reports we know they will ask for (with screenshots!)
- Leadership
  - Ensure reports are being ran (if not already in Survey Binder)
  - Who to gather for Entrance Interview
  - Obtain Survey Binder and bring to Entrance Interview
  - Be prepared to answer the sample survey questions

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How to Organize your Survey Prep

EVERYONE is involved

Cuecards or Cheatsheets for EVERYONE!

- Field Clinicians
  - Reminders on Bag technique (never on floor-unless wheeled, clean hands before entering bag, zip close after removing all of clean equipment, clean equipment before returning to bag
  - Reminders of common infection control issues (clean hands after touching computer keys/screen/phone, clean hands in between glove changes, change gloves and clean hands between wounds when more than one)
  - Reminders to do COVID-19 screen on patient and ensure proper PPE
  - Medication reconciliation must-dos!
  - Use Home Worksheet for self-checks of tandem visits!

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Survey Binder- the BEST Tool for Prep

See Table of Contents Tool provided!

Modify, if needed, for your state

Gather all of the "constants"- things that don't change frequently

- Organizational Chart
- Admit Packet
- Specific Policies and Procedures listed on TOC
- List of employees/contractors
- If Deemed status with an AO, then include CASPER reports

When survey is close- consider running reports each Monday morning to be "extra prepared"

- See list of reports on TOC

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SURVEY PREPARATION GUIDE

Provided By: Provider Insights, Inc.

As the survey time approaches, please print these first 5 items and keep them on file. They must be presented within 1 hour of the start of the survey.

1) Visit schedules for the first week of the survey for each nurse, therapist and SW (for each branch, if applicable). Identify patients with high tech services, wound care, pediatric patients and comprehensive assessment visits.

2) The number of unduplicated skilled admissions in the last 12 months. (This is an admission number, NOT a census number. Count each patient only once, regardless of how many admissions an individual patient might have during that period.)

3) A list of all current patients, (exclude homemaker only cases) including start of care, pay source, primary diagnosis and services provided. Identify patients under the age of 18 and if agency has branch offices, identify which office the patient receives services from.

4) A list of patients discharged in the last 6 months, including start of care, discharge date and reason for discharge.

5) A list of all patients with a resumption of care and/or significant change in condition in last 6 months.

(Computer charting or paper charts? If computer charting, computers must be provided to the surveyors within 2 hours.)

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Additional Items Needed:

Policies:

- All comprehensive assessment policies (for OASIS and OASIS exempt patients)
- Drug Regimen Review policy
- Protection of Clinical Records policy
- Plan of Care policies
- Emergency Preparedness policies
- Home Health Aide Supervision policy
- Home Health Aide Assignment / Care Plan policy
- Wound Assessment / Measurement policy
- Handwashing / Home Health Aide Bag policy
- Timeliness Clinical Record Documentation policy
- Timeliness of Initiation of Therapy Services policy
- Abuse policies

Other:

- An admission packet
- Evidence the governing body appointed the Administrator
- Any abuse investigations since the last survey and any related policies

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Home Visits + Chart Reviews

PROVIDER INSIGHTS

Table 2. Survey Sample Table

Number of Unduplicated Skilled Admissions for the Past 12 Months	*Closed Record Review (Discharged)*	*Active Sample: Home Visit with Record Review*	*Active Sample: Record Review Only*	*Total Patient Sample (Minimum)*
Less than 300	*2*	*3*	*2*	*7*
301 - 500	*3*	*4*	*3*	*10*
501 - 700	*4*	*5*	*4*	*13*
701 or more	*5*	*7*	*5*	*17*

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PROVIDERINSIGHTS

Survey
Preparation Patient Home

1. **Medications**
   - ☐ Ensure all medications are accounted for on the list in the medical record.
   - ☐ Ensure all components of Drug Regimen Review are complete. Are there any symptoms or body systems that are being treated with more than one med? (two antihypertensives? Two pain meds? Two inhalers?) This is a duplicate med therapy. Are there any symptoms that are not controlled by current meds? This is "ineffective medication".
   - ☐ Ensure all medications have time of day spelled out clearly.
   - ☐ All PRNs must have qualitative reasons (when necessary).
   - ☐ All meds not being used or expired will be separated out (if at home)- (suggest gallon baggie with STOP sign).
2. **Plan of Care**
   - ☐ Review POC to ensure still accurate.
   - ☐ Look at DME listed on POC. Ensure all items in the home are listed that may assist the patient to stay in home safely. Remember can include typical DME, as well as scales, hand-held shower, med box, blood glucose machine, CPAP, grab bars, incontinence pads, reacher, etc.

Home Visit Preparation

Tandem visits to prepare both clinician and patient for any survey home visits

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3. Patient Home Folder

- ☐ Copy of patient's rights.
- ☐ Copy of "Mini Plan of care"- kept updated if new treatments or instructions.
- ☐ Calendar updated with who is coming/when.
- ☐ Emergency care plan.
- ☐ Current medication list.

4. Inform Patient

- ☐ Educate the patient about the need to keep home folder in same location.
- ☐ Re-educate patient on contents of home folder and ensure patient knows how to reach agency.

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484.50 (CONDITION)

Patient Rights

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Notification 484.50a

STANDARD LEVEL

- Terms the patient understands
- Written
- Verbal (don't need to read- but summarize)

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Rights of the Patient 484.50c

§484.50(c) Standard: Rights of the patient. The patient has the right to—

(1) Have his or her property and person treated with respect;

(2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;

(3) Make complaints to the HHA regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the HHA

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Survey Procedures: §484.50(c)(2)

Examine the extent to which the HHA has a system in place to protect patients from abuse, neglect, and misappropriation of property of all forms, whether from staff or from other persons. Determine the extent to which the HHA addresses the following issues:

- *How does the HHA staff conduct themselves in the patient's home in regards to demonstrating respect for persons and property?*
- *Does the HHA have policies and procedures for investigating allegations of abuse, neglect and misappropriation of property?*
- *Interview staff to determine if staff members know what to do if they witness abuse, neglect or misappropriation of property.*
- *Ask the HHA if it has had any allegations of patient abuse or neglect from any source during the past year. If it has, ask the HHA to provide the files and to describe how the matter was handled. Review the HHA records to see if the appropriate agencies*

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Rights of the Patient 484.50c

(4) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to –

(i) Completion of all assessments;

(ii) The care to be furnished, based on the comprehensive assessment;

(iii) Establishing and revising the plan of care;

(iv) The disciplines that will furnish the care;

(v) The frequency of visits;

(vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;

(vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished.

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Rights of the Patient 484.50c

(5) Receive all services outlined in the plan of care.

(6) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.

Survey procedures §484.50(c)(6) Verify that the agency staff maintain the confidentiality of protected health information that they transport and use.

(7) Be advised, orally and in writing, of— (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (iii)The charges the individual may have to pay before care is initiated;

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Advise of hotline and supports

(9) Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs.

(10) Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides:

(i) Agency on Aging

(ii) Center for Independent Living

(iii)Protection and Advocacy Agency,

(iv) Aging and Disability Resource Center; an

(v) Quality Improvement Organization.

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No grief for exercising rights!

(11) Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HHA or an outside entity.

Note to surveyor during home visit:

Inquire if the patient filed any complaints directly with the HHA and if the care and services were negatively affected by this action. Determine if the patient is aware of the state HHA hotline to lodge a complaint if dissatisfied with the care provided by the HHA (§484.50(c)(9)).

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Transfer/DC 484.50d

ONLY in those 7 situations- be sure you policy follows these!

(1) The transfer or discharge is necessary for the patient's welfare

(2) The patient or payer will no longer pay for the services provided by the HHA;

(3) Provider agrees patient goals met or no longer needs Home Health

(4) Patient refuses further services or asks to be transferred or discharged

(5) For "cause"… (see the additional steps necessary)

(6) Patient dies

(7) Agency closes

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DC “for cause”

The clinical record should reflect:

- Identification of the problems encountered;
- Assessment of the situation;
- Communication among HHA management, patient caregiver, legal representative and the physician responsible for the plan of care;
- A plan to resolve the issues; and
- Results of the plan implementation.

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484.50e Investigation of Complaints

(i) Investigate complaints made by a patient, the patient’s representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics:

(A) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately;

(B) Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA.

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484.50e What else about complaints?

(ii) Document both the existence of the complaint and the resolution of the complaint; and

(ii) Obtain the complaint log (or other format used for documenting complaints) to verify that the HHA is tracking complaints received from receipt of complaint through resolution.

(iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated.

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484.55 (CONDITION)

Initial and Comprehensive Assessments

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484.55a Initial assessment

- Mandates timeframe
  - Two days from referral (let's define!) OR
  - Two days from the inpatient DC date OR
  - On the date the provider ordered us to go!

- AND… pop quiz… what are the two things we MUST do to perform the initial visit?
  - Assess- what are the patient's immediate care needs?
  - Assess- do they qualify for Medicare, if Medicare is the payer (reviewing HB status, etc)

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WHO can do the initial?

If nursing is ordered at all- it must be the RN

If therapy **only** – any therapist can do the initial visit and the SOC comprehensive assessment (including OASIS)

- What are your processes?
- Do you let OT do SOC?
- Can OT stand alone for Medicare payment?

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484.55b Comprehensive assessment

- SOC Comprehensive must be done "timely" – five days MAXIMUM
  - SOC date = day "0"
  - May collaborate with other team members, or make changes based on additional visit- IF making any changes due to new assessment information- then M0090 must be updated

- If nursing is ordered, again, the RN must complete the "Initial" and the SOC comprehensive assessment- (See instructions to surveyors!)
  - *Through clinical record review, verify the initial assessment was conducted by a registered nurse unless the patient is receiving therapy services only.*
  - *Through home visit observation, verify if the current comprehensive assessment and plan of care were completed and accurately reflect the patient's status.*

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484.55c Content of Comp assessment

(1) The patient's current health, psychosocial, functional, and cognitive status;

(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA

(3) The patient's continuing need for home care;

(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs;

AND- the Drug Regimen Review…

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484.55c(5) Content- Drug regimen review

(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including:

(MUST CONTAIN THESE FIVE THINGS FOR SURVEY!)

1. ineffective drug therapy,
2. significant side effects,
3. significant drug interactions,
4. duplicate drug therapy, and
5. noncompliance with drug therapy.

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Must start with Med Reconciliation!

What's included?

The patient's clinical record should identify all medications that the patient is taking, both prescription and non-prescription (e.g., over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy)

(The medication scavenger hunt, or medication Easter egg hunt!)

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CMS flip-flop on who can assess/DRR

As of updated SOM in 2024:

"Each agency must determine the capabilities of current staff members to perform comprehensive assessments, considering professional standards or practice acts specific to the State. No specific discipline is identified as exclusively able to perform the medication review. However, only Registered Nurses (RNs), Physical Therapists (PTs), Occupational Therapists (OTs) and Speech-Language Pathologists (SLPs) are qualified to perform comprehensive assessments (see also §484.55(b)). While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, the agency may develop a policy where clinicians may collaborate to collect data for all OASIS items. For example, to assess potential side effects and drug interactions, the agency may wish to have RNs or practical (vocational) nurses"

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Back to the rest of 484.55c Content

(6) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules;

(7) The patient's representative, if any

(8) Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items

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484.55d Updates of the Comp assessment

FIRST update mentioned- whenever the patient's condition or changes warrant a new assessment… What timepoint is that??

But, no less often than,

(1) The last 5 days of every 60 days beginning with the start-of-care date,

(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner -ordered resumption date;

(3) At discharge.

Pop quiz: Why didn't we mention the transfer or death?

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484.60 (CONDITION)

Care planning, coordination of services, and quality of care.

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POC Condition language- ties to Acceptance
(if we can't have a winning plan- can't accept)

Patients are **accepted for treatment** on the **reasonable expectation that an HHA can meet** the patient's **medical, nursing, rehabilitative, and social needs in his or her place of residence**.

- "Reasonable expectation".. means: consideration of the patient's level of acuity, the HHA can effectively and safely provide the patient with the skilled services that the patient needs within the patient's home.

Each patient must receive an **individualized written plan of care**, **including** any **revisions** or **additions**.

The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible **discipline(s)**, and the **measurable outcomes** that the HHA anticipates will occur as a result of implementing and coordinating the plan of care.

The individualized plan of care must also specify the **patient and caregiver education** and training. Services must be furnished in accordance with accepted standards of practice.

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484.60a Plan of Care

Key emphasis on personalization of the interventions and goals for each patient

Survey guidance states: *"Patient-specific measurable outcome" is a change in health status, functional status, or knowledge, which occurs over time in response to a health care intervention that provides end-result functional and physical health improvement/stabilization.*

Also states we should use patient input for POC

Updated survey instructions verifies- no ORDER needed for missed visits- simply a notification!

…the HHA should make every attempt to reschedule the missed visit. If the visit cannot be rescheduled, the responsible physician or allowed practitioner should be notified, and the HHA should document the potential clinical impact of missed treatments or services. The HHA should advise and educate the patient on the potential impacts of missed visits.

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484.60a- POC should include all orders

- All patient care orders, including verbal orders are part of the plan of care.
- The plan of care **may include orders** for treatment or services received from physicians **other than the responsible physician.**
- The **plan should be revised to reflect any verbal order** received during the 60-day certification period **so that all HHA staff are working from a current plan**. It is not necessary for the physician to sign the plan of care again until recertification
  - (Annette added- but provider must sign verbal orders, of course)
  - How do you integrate verbal orders along the way?

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484.60b More re: verbal orders

How do you "authenticate" a verbal order? What must be included?

When does it need signed?

Does it need dated?

Are credentials needed?

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What if things change?

§484.60(c)(1) . . . The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

Survey Procedures §484.60(c)(2) The clinical record should demonstrate that patients are assessed throughout the episode of care to assure that HHA services meet the needs of the patient; changes in a patient's status are consistently communicated; and the plan of care is updated as needed.

This is a big citation! Many times due to poor outcomes. Has landed Immediate Jeopardy!

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484.60(d) Coordination of Care.

With the ordering providers:

- ❑Assure communication with all physicians or allowed practitioners involved in the plan of care.
- ❑Integrate orders from all physicians or allowed practitioners involved in the plan of care to assure the coordination of all services and interventions provided to the patient
  - ❑Communicate changes and new orders with "relevant" providers

With the team:

- ❑Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.

AND with the patient and family/caregivers

Survey instruction: Determine through interview if the patient, representative, and caregiver, as applicable and appropriate, are involved in care coordination. For example, were individual schedules considered and accommodated as able?

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Case conferences

- Formal case conferences are NOT mandated by regulation
- How do you coordinate and show this in the medical record?
  - Benefits? Drawbacks?
- What is discussed during these conversations?
  - OASIS accuracy?
  - Utilization?
  - DC planning- keeping everyone in the loop?

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Speaking of DC planning…484.60d

Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.

Survey: If education was conducted, did the HHA staff provide education and training to the patient and any caregivers, when appropriate, and according to the plan of care? Look for evidence that the education was conducted by reviewing the written information in the patient's home and/or interviewing the patient and HHA staff.

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484.60e Written information to patient

Instructs the agency must provide these five things in writing to the patient, but does not prescribe how that is done…

For instance-

(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.

How do you do this? Calendar? Send the POC? Write out what you know now and update?

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(con't) Medication list

§484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA.

Survey Procedures: Review the most current medication list that the HHA personnel provided to the patient. Determine if the medications match those listed in the comprehensive assessment, the plan of care, and the written information to the patient. Investigate any discrepancies for additions or deletions to the medications since the information was last updated by the HHA.

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Treatments, instructions and who to call

§484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.

- How do you do this? Remember keep it simple- "Nurse to provide care to wound" is adequate

(4) Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs.

- Take your paid medication prior to therapy, or prior to nurse coming to treat wound

(5) Name and contact information of the HHA clinical manager.

- Instruct this is when there are additional clinical concerns and wants to discuss

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Your Plan for Home Health

What is your goal that home health can assist you with?

_____

_____

Your Representative: _____

Planned home health team members/frequency:

Nurse: _____ Physical Therapist: _____

Occupational Therapist: _____ Speech Therapist: _____

Home Health Aid: _____

_____

Treatments to be done by your home health team: _____

_____

_____

Special instructions you need to know regarding your health or home care:

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Treatments to be done by your home health team: _____

_____

_____

Special instructions you need to know regarding your health or home care:

_____

_____

Symptoms to report to your home health agency:

- Increased pain, and medications not working as before.
- Increase shortness of air.
- Swelling in your feet and legs - increased from your "normal".
- Change in your ability to move around your home.

If you have concerns, or questions- we want to know!

Please call _____, Clinical Manager, at _____

Client name _____ Date provided _____

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484.65 (CONDITION)

QAPI:
Quality Assessment Performance Improvement

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QAPI Condition

- The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program.
- The HHA's governing body must ensure that the program reflects the complexity of its organization and services;
- involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions;
- and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors.
- The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.

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What's included?

(1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program.

(i) Focus on high risk, high volume, or problem-prone areas;

(ii) Consider incidence, prevalence, and severity of problems in those areas; and

(iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.

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TOPIC
Average case mix (1.0)
Average # of 30 day periods per stay
Total Falls (% of falls per total patients served in quarter)
Unique Patients w fall
Falls with major injury
Infections (pt) UTI
Total UTI % (% of UTI per Total patient served in Quarter)
Infections (pt) URI
Infections (pt) COVID
Infections (pt) Skin
Sepsis
Infections (pt) Other
Total infections
Total infections (% of infections per total patients served in quarter)
Admitted vs Acquired Infections %
Employee Infections Respiratory/skin
Complaints/concerns % of complaints per patient served in quarter

Complaints/concerns % of complaints per patient served in quarter
OASIS Submission timeliness
Five star preview scores total
Timely initiation of care (from five star preview reports)
Improvement in medication mgmt. (M2020)
Improvement in ambulation (M1860)
Improvement in bathing (M1830)
Improvement in bed transfers (M1850)
Improvement in dsypnea (M1400)
Potentially preventable hospitalization rate
CMS HHVBP TPS
CMS CAHPS % reply
CMS CAHPS scores
Audits/findings/results

Quarter 1 Quarter 2 Quarter 3 Quarter 4

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Who's involved?

- Governing body must approve data collected, frequency of collection
- All team (and contractors) may be involved in QAPI- not to be just one person's job
- Team members brought in to assist with root cause analysis and creating plans to impact these quality areas

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484.65d Performance Improvement Plan

- Must have one PIP per year
- Surveyor instructions:
- *• Ask the HHA to show you documentation for performance improvement projects currently underway, as well as those completed in the prior year.*
- *• Does the HHA's documentation indicate the rationale for undertaking each project? Does the HHA have data indicating it had a problem in the area targeted for improvement, or could the HHA point to recommendations from a nationally recognized expert organization suggesting the activities?*
- *• Does the documentation for the completed project(s) include the project's results? If a project was unsuccessful, ask the HHA what actions it took because of that information. If the project was successful, ask the HHA how it is sustaining the improvement.*

59

And, don't forget the Governing Body …

Surveyor instructions:

Ask the HHA for information about its governing body. If there are questions about who constitutes the HHA's governing body, it may help to review the information the HHA reported on its CMS Form 855A application, identifying those individuals with ownership interest or managing control of the HHA.

• Ask to see meeting minutes or other evidence of how the governing body exercises ongoing oversight of and accountability for the HHA's QAPI program.

60

484.70 (CONDITION)

Infection Control

61

Infection control focus- your Policy!

- *Surveyors will focus their observation of infection control practices by the HHA during home visits.*
- *Determine whether the policies and procedures of the HHA's infection control program are implemented correctly based on observations of care.*
- *Determine that there is an ongoing, documented program for the prevention and control of infections and communicable diseases among patients and HHA personnel.*

Prevention, Control,

62

63

Home visits, co-visits!

PROVIDER INSIGHTS

- Make sure your staff are familiar with infections control policies before the survey begins
- Co-visits by agency administrative staff can help lessen the anxiety of the staff member being watched by another person and help determine the staff member's infection control competency or incompetency
- Medications will always be reviewed by the surveyor every visit- make sure to clinicians are familiar with DRR policies and get used to assessing for new medications each visit as the surveyor will be observant of such in the environment and by interview of the patient/caregiver.
- Ensure the clinician always has a POC to refer to during the home visit to address each intervention as ordered by the physician.

64

64

484.70a Prevention: Hand hygiene

1. Hand Hygiene HHAs and surveyors are advised to review the most current CDC's hand hygiene recommendations for correct procedures. Hand Hygiene should be performed (and your policy should include):

- Before and after contact with a patient;
- Before performing an aseptic task (e.g., insertion of IV, preparing an injection, performing wound care);
- After contact with blood, body fluids or contaminated surfaces;
- After contact with the patient's immediate environment;
- When moving from a contaminated body site to a clean body site during patient care; and
- After removal of personal protective equipment (e.g., gloves, gown, facemask).

The HHA must ensure that supplies necessary for adherence to hand hygiene are provided.

65

Prevention: Environment cleaning & safety

- Cleaning and disinfecting or placing a clean barrier on the surface in the home where clean equipment will be placed and/or preparation of injectable medications will be performed.
- Additionally, items that are taken from one home to another should be cleaned and disinfected in accordance with accepted standards of practice, which include manufacturer's instructions for use.
- Cleansing of all multi-use items (BP cuff, stethoscope, pulse ox, etc) before putting into "clean area" for transportation and using on another patient. (KNOW the INSTRUCTIONS on your product!)
- Then, the interpretive guidelines speaks to medication and injection/needle safety to decrease contaminants and appropriate use of PPE
- And minimizing respiratory exposures…

66

484.70b Infection Control

The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program.

• Clinical record review; • Staff reporting procedures; • Review of laboratory results; • Data analysis of physician or allowed practitioner and emergency room visits for symptoms of infection; and • Identification of root cause of infection through evaluation of HHA personnel technique and self-care technique by patients or caregivers.

67

484.70c Education for patients

The HHA must provide infection control education to staff, patients, and caregiver(s).

The regulation does not specify the form or content of education regarding infection prevention and control. However, in accordance with requirements under §484.60, patients and caregivers must be provided with education and training specific to the individualized plan of care. HHAs should also take into consideration the patient's and caregiver(s)' health conditions and individual learning needs. The HHA should review training information with the patient and his or her representative (if any), including information on how to clean and care for equipment (e.g., blood glucose meters or reusable catheters), at sufficient intervals to reinforce comprehension of the training.

68

Education for staff

"Should include"…

• Information on appropriate use, transport, storage, and cleaning methods of patient care equipment according to manufacturer guidelines/instructions for use;

• Job-specific, infection prevention education and training to all health care personnel for all of their respective tasks;

• Processes to ensure that all health care personnel understand and are competent to adhere to infection prevention requirements as they perform their roles and responsibilities;

• Written infection prevention policies and procedures that are widely available, current, and based on current standards of practice;

.

• Training before individuals are allowed to perform their duties and periodic refresher training as designated by HHA policy;

• Additional training in response to recognized lapses in adherence and to address newly recognized infection transmission threats (e.g., introduction of new equipment or procedures);

• Infection control education provided to staff at periodic intervals consistent with accepted standards of practice. **Such education must be provided at orientation, annually, and as needed to meet the staff's learning needs to provide adequate care; identify infection signs and symptoms; identify routes of infection transmission; appropriately disinfect/sanitize/transport equipment and devices used for patient care; and use proper medical waste disposal techniques. Such education must include instructions on how to implement current infection prevention/treatment practices in the home setting**

69

484.75 (CONDITION)

Skilled Professional Services

70

Responsibilities of skilled professionals

(1) Ongoing interdisciplinary assessment of the patient;

(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s);

(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care;

(4) Patient, caregiver, and family counseling;

(5) Patient and caregiver education;

(6) Preparing clinical notes;

(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care;

(8) Participation in the HHA's QAPI program; and

(9) Participation in HHA-sponsored in-service training.

71

Supervision of assistants and LPN/LVNs

Then defines minimum requirements for RNs, therapists, MSW

Responsible for supervision of assistants (PTA, COTA) and LPN/LVN

State scope of practice acts define specifically how often, conditions to be met with supervision of assistants and LPN/LVNs

72

484.80 (CONDITION)

Home Health Aide

73

484.80a Four methods to be an aide

PROVIDER INSIGHTS

The regulation describes four methods by which a home health aide may become qualified:

(i) A training and competency evaluation program as specified in paragraphs (b) and (c) respectively of this section; or

(ii) A competency evaluation program that meets the requirements of paragraph (c) of this section; or

(iii)A nurse aide training and competency evaluation program approved by the state as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the state nurse aide registry; or

(iv) The requirements of a state licensure program that meets the provisions of paragraphs (b) and (c) of this section.

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Core competencies- “personal cares”

(i) Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff;

(iii) Reading and recording temperature, pulse, and respiration;

(ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks that include—

(A) Bed bath; (B) Sponge, tub, and shower bath; (C) Hair shampooing in sink, tub, and bed; (D) Nail and skin care; (E) Oral hygiene; (F) Toileting and elimination;

(x) Safe transfer techniques and ambulation;

(xi) Normal range of motion and positioning.

**Anything not on the list must be “checked off” by RN prior to provision (shaving, TED hose, etc) and must be listed separately on the physician POC

75

484.80e 12 hours in-service for aides

Must be supervised by RN

Provided by agency- in any format

Must have documentation of these inservices

The required 2 years of nursing experience for the RN instructor should be “hands on” clinical experience such as providing care and/or supervising nursing services or teaching nursing skills in an organized curriculum or in-service program. At least 1 year of experience must be in home health care.

“Other individuals” who may help with home health aide training would include health care professionals such as: • Physicians; • Physical therapists; • Occupational therapists; • Speech-language pathologists; • Medical social workers, • LPN/LVNs;

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484.80g Assignments

(1) Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist).

Must be SPECIFIC!

When both nursing and therapy services are involved, *either skilled professional may assign home health aides and develop written patient care instructions*.

(i) The provision of hands on personal care;

(ii) The performance of simple procedures as an extension of therapy or nursing services;

(iii) Assistance in ambulation or exercises; and

(vi) Assistance in administering medications ordinarily self-administered.**

77

What about these meds?...

"Self-administration of medications" means that the patient (or the patient's caregiver, if applicable) can manage all aspects of taking her or his medication, including safe medication storage, removing the correct dose of medication from the container, taking the medication at the correct time, and knowing how to contact the pharmacy for refills or other questions.

Aide must have a passive role, such as:

• Bringing a medication to the patient either in a pill organizer or a medication container as requested by the patient or caregiver;

• Providing fluids to take with the medication;

• Reminding the patient to take a medication;

• Applying a topical product, such as a non-prescription cream, to intact skin per home health aide instructions in how to apply it.

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484.80h Supervision

If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services—

(A) A **registered nurse** or other appropriate **skilled professional** who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided **no less frequently than every 14 days; and**

(B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section.

79

Supervision onsite by skilled personnel

The supervisory assessment must be completed onsite (that is, an in person visit***), or on the rare occasion by using two-way audio-video telecommunications technology that allows for real-time interaction between the registered nurse (or other appropriate skilled professional) and the patient, not to exceed 1 virtual supervisory assessment per patient in a 60-day episode.***

If an area of concern in aide services is noted by the supervising registered nurse or other appropriate skilled professional, then the supervising individual must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.

(New) §484.80(h)(1)(iv) A registered nurse or other appropriate skilled professional must make **an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.**

80

Contents of supervision documentation

(i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional;

(ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family;

(iii) Demonstrating competency with assigned tasks;

(iv) Complying with infection prevention and control policies and procedures;

(v) Reporting changes in the patient's condition; and

(vi) Honoring patient rights.

81

484.105 (CONDITION)

Organization and administration of services.

82

Defines structure and roles

- Governing body
- Administrator
- Clinical manager
- Branches
- Services under arrangement

Call them what you like- but CMS calls them by these names- so be sure to include in your job descriptions as such!

Under this condition there are also standards about budget, planning, etc

484.115 Personnel qualifications defines further education and experience

83

484.110 (CONDITION)

Clinical Records

84

484.110a Contents of clinical records

(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders

(2) All interventions, including medication administration, treatments, and services, and responses to those interventions;

(3) Goals in the patient's plans of care and the patient's progress toward achieving them;

(4) Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s);

(5) Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA;

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(con't) Contents… DC/Transfer summaries

(6)(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or

(ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or

(iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.

(NOTE- this does NOT need to meet the definition of the "Transfer" for OASIS!)

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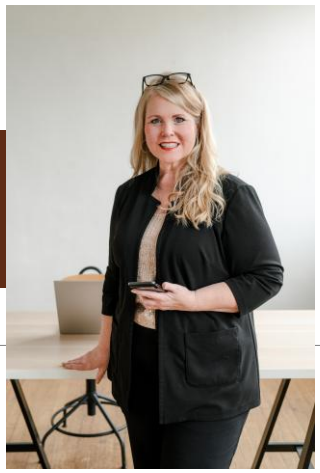
Questions?



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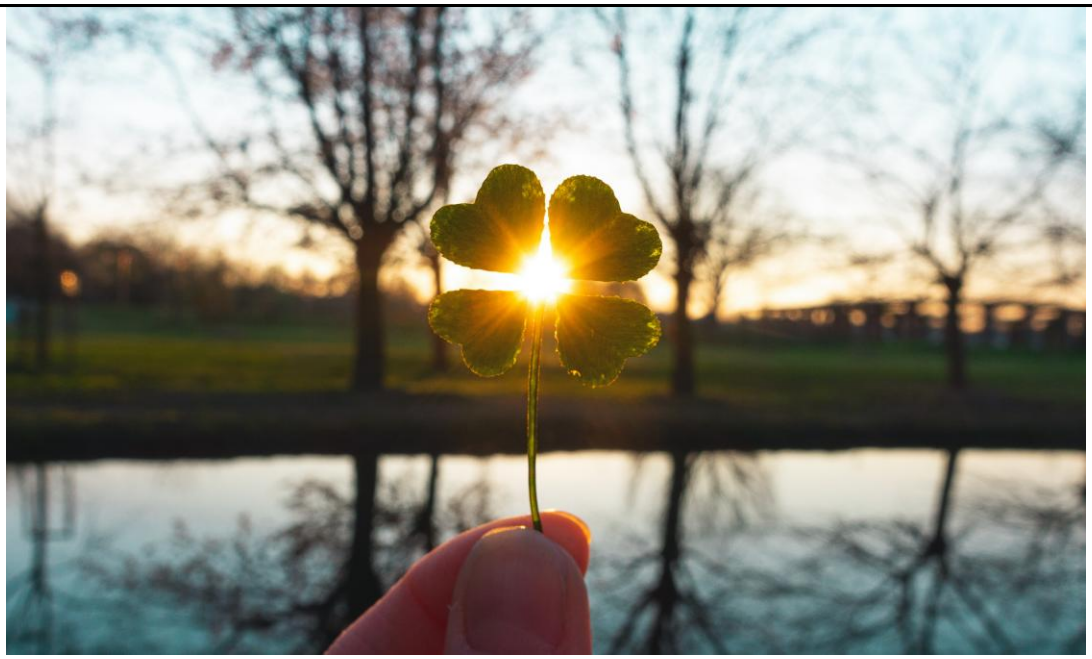

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POTENTIALLY AVOIDABLE EVENT REVIEW

Patient Name:

SOC:

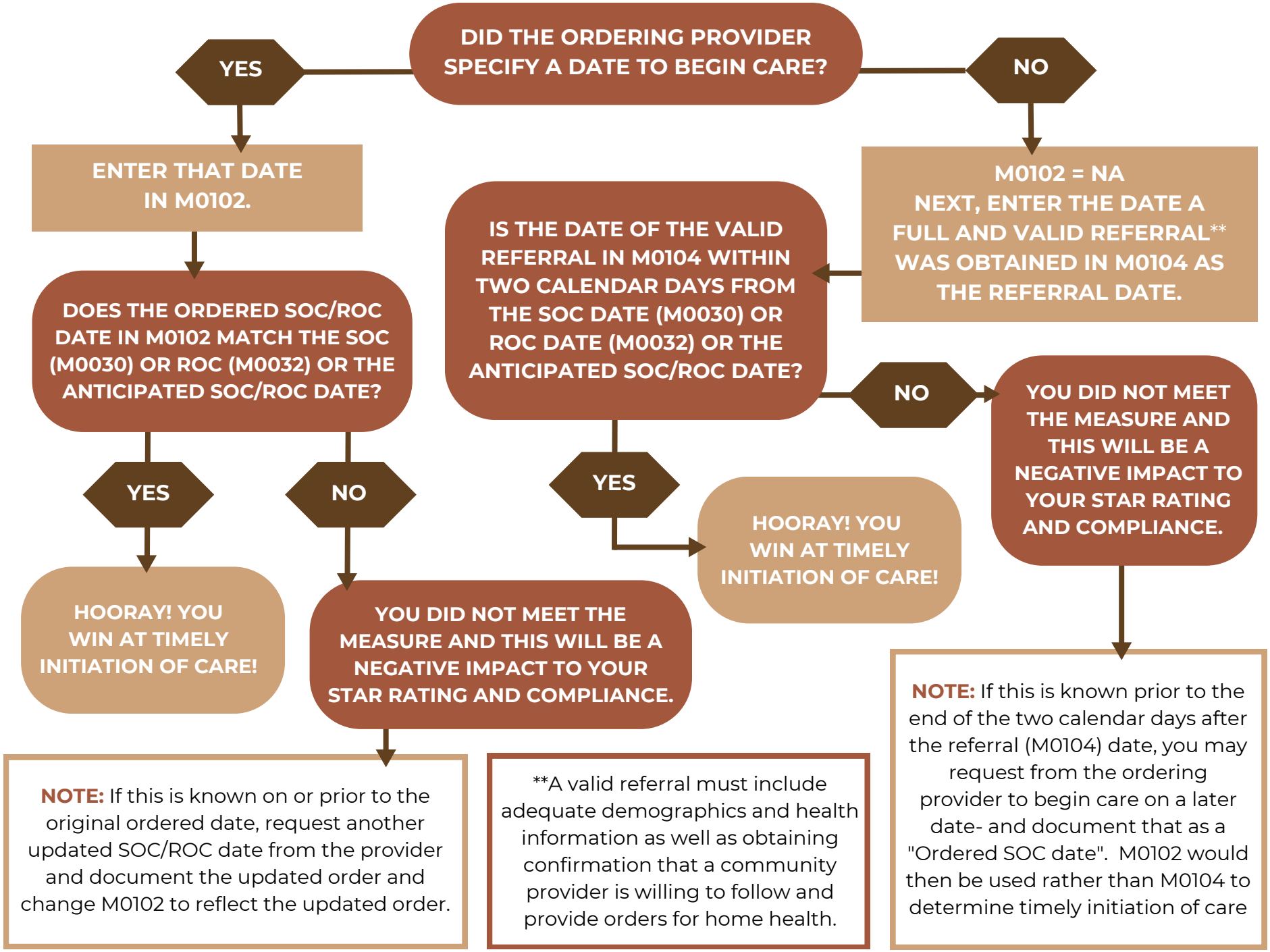
TRF/DC related to PAE:

PAE: ER Utilization related to Medication Issues

Was the POC appropriate for the patient needs?	Yes/no, expand- what disciplines are involved/high level view of interventions
Was the POC followed?	Did the disciplines visit at ordered frequency and provide interventions ordered?
Was there documentation re: assessment and teaching around medications?	
Is it clear which medication(s) may have led to the ER visit?	
If patient remained on service, was the POC updated accordingly?	Such as increased utilization, bringing in nursing if wasn't part of POC prior, teaching on meds, etc.
Was there something the HHA could have done differently based on known risks to decrease the likelihood of this ER visit related to medication issues?	

PROVIDER INSIGHTS

TIMELY INITIATION OF CARE



NOTE: If this is known on or prior to the original ordered date, request another updated SOC/ROC date from the provider and document the updated order and change M0102 to reflect the updated order.

**A valid referral must include adequate demographics and health information as well as obtaining confirmation that a community provider is willing to follow and provide orders for home health.

NOTE: If this is known prior to the end of the two calendar days after the referral (M0104) date, you may request from the ordering provider to begin care on a later date- and document that as a "Ordered SOC date". M0102 would then be used rather than M0104 to determine timely initiation of care

PROVIDERINSIGHTS

Home Health

Survey Preparation Guide

January, 2026

Print the Following

As the survey time approaches, please print these first 5 items and keep them on file. They must be presented within 1 hour of the start of the survey.

1) Visit schedules for the first week of the survey for each nurse, therapist and SW (for each branch, if applicable). Identify patients with high tech services, wound care, pediatric patients and comprehensive assessment visits.

2) The number of unduplicated skilled admissions between _____ and _____. (This is an admission number, NOT a census number. Count each patient only once, regardless of how many admissions an individual patient might have during that period.

3) A list of current patients, including start of care, pay source, primary diagnosis and services provided. Identify patients under the age of 18 and if agency has branch offices, identify which office the patient receives services from.

4) A list of patients discharged in the last 6 months, including start of care, discharge date and reason for discharge.

5) A list of all patients with a resumption of care and/or significant change in condition in last 6 months.

(Computer charting or paper charts? If computer charting, computers must be provided to the surveyors within 2 hours.)

Provide the Following

AFTER the above items, please provide the following information:

1) The current census _____ .

2) A list of current staff with title and date of hire (identify clinical supervisors, department managers, home health aide coordinators, etc. and, if agency has branch offices, which office the person works out of).

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3) A list of all staff hired or contracted since the last survey that have left the agency.

4) List of all current contracted staff, including title and date the staff person started providing services to agency patients.

5) The current number of patients receiving home health aide services with every 14 day supervision _____ and with 60 day supervision _____ .

6) Number of patients receiving wound care _____ .

7) The Agency Complaint/Grievance log for the last year and any related policies.

8) An organizational chart.

9) Fiscal intermediary? _____ . Fiscal Year Ending? _____ .

10) Are you accredited or deemed? And if so, with which accrediting organization? _____ .

11) The day the work week begins for the Plan of Care? _____ .

12) What is done if visit frequency differs from the Plan of Care? _____ .

13) Number of staff: HHA _____ LPN _____ .

14) Agency Hours: _____ . Fax number: _____ .

15) Any branches? _____ . Location of each:

16) Provide a map of the agency's approved geographic service area, and a written list of the same; showing entire counties if all of the county is served; and showing townships if only part of a county is served. The surveyor will provide a township map if needed.

Additional Items Needed

Policies:

- All comprehensive assessment policies (for OASIS and OASIS exempt patients)
- Drug Regimen Review policy

- Protection of Clinical Records policy
- Plan of Care policies
- Emergency Preparedness policies
- Home Health Aide Supervision policy
- Home Health Aide Assignment / Care Plan policy
- Wound Assessment / Measurement policy
- Handwashing / Home Health Aide Bag policy
- Timeliness Clinical Record Documentation policy
- Timeliness of Initiation of Therapy Services policy
- Abuse policies

Other:

- An admission packet
- Evidence the governing body appointed the Administrator
- Any abuse investigations since the last survey and any related policies

PROVIDERINSIGHTS

Home Health

Surveyor Probe Questions for Patients/Caregivers

March, 2026

Per the CMS State Operation Manual

Patient / Caregiver Interview Probe Questions

(Ask in the home or by phone)

A. RIGHTS, COMPLAINTS, AND SAFETY

- Can you tell me **what your rights are** as a home health patient, **and how the agency explained them?**
- If you had a complaint, **how would you file it** (and who would you contact)?
- Have you ever felt **unsafe, disrespected, or that your property was mishandled** by any staff?
- Do staff act respectfully in your home and with your belongings?

B. SERVICES, COVERAGE, AND FINANCIAL NOTICES

- Did the agency tell you **if any services might not be covered by Medicare,** and what would happen if they weren't covered?
- If you received a **non-coverage notice,** did you get it **before** the care/service was provided?

C. PLAN OF CARE INVOLVEMENT AND COMMUNICATION

- What services are you receiving and how often—and does that match what you expected?
- When something changes (frequency, disciplines, goals), **does the agency tell you before the change happens,** and do you get a chance to participate?

- How do you know what your current goals are—and do you feel they reflect what matters to you?
- Are plan-of-care changes communicated to you consistently (and do you recall examples)?

D. AFTER-HOURS AND ESCALATION

- If you had a problem after hours, **who would you call first**—your physician, the agency, or someone else?
- Do you know how to reach the agency **24/7,** and have you used that option? (What happened?)

E. MEDICATION MANAGEMENT & TEACHING

- Who reviews your medications with you?
- Do you understand what each medication is for and what side effects to watch for?
- Have you had any medication problems (missed doses, confusion, adverse effects)? What did the agency do?

F. INFECTION PREVENTION IN THE HOME

- Do staff **clean their hands** before care and follow the hand hygiene agency policy?
- Did the staff follow their agency policy for bag technique/cleaning equipment?
- Do they bring clean equipment/supplies and keep dirty items separated?
- If you had a wound/catheter/IV, do you feel the teaching was clear and safe?

G. DISCHARGE/TRANSFER EXPERIENCE (IF APPLICABLE)

- Were you told ahead of time about discharge/transfer?
- Did the agency explain why, and what services you'd have afterward?

PROVIDERINSIGHTS

Your Plan for Home Health

What is your goal that home health can assist you with?

_____

_____

Your Representative: _____

Planned home health team members/frequency:

Nurse: _____ Physical Therapist: _____

Occupational Therapist: _____ Speech Therapist: _____

Home Health Aid: _____

_____

Treatments to be done by your home health team: _____

_____

_____

Special instructions you need to know regarding your health or home care:

_____

_____

Symptoms to report to your home health agency:

- Increased pain, and medications not working as before.
- Increase shortness of air.
- Swelling in your feet and legs - increased from your “normal”.
- Change in your ability to move around your home.

If you have concerns, or questions- we want to know!

Please call _____, Clinical Manager, at _____

Client name _____ Date provided _____