FALL/WINTER 2021

Quality Review Edition

THE SURVEYOR

HOME INFUSION THERAPY

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MISSION STATEMENT

Accreditation Commission for Health Care (ACHC) is dedicated to delivering the best possible experience and to partnering with organizations and healthcare professionals that seek accreditation and related services.

CORNER VIEW

In the fall of 2020, ACHC merged with the parent company of the first U.S. healthcare accreditation program, HFAP. The merger added CMS-deemed accreditation for facility-based care including acute care hospitals, ambulatory surgery centers, clinical laboratories, critical access hospitals; non-deemed accreditation for office-based surgery; and certification for stroke care, wound care, joint replacement, and lithotripsy to ACHC's existing portfolio of community-based accreditation and education programs.

Part of the assimilation process has been to audit our distinct resources in order to bring the very best from each separate entity to our new, unified company. You are reading one result of that exercise. **The Surveyor** is an ACHC legacy publication, but the Fall/Winter edition now parallels what was previously HFAP's annual **Quality Review**. That publication examined the most frequently cited deficiencies for each accreditation program to give organizations a tool for benchmarking and improving their performance.

> **While healthcare is constantly evolving, we are currently emerging from a time of unusually rapid change.**

In years past, ACHC identified frequent deficiencies by program and made them available annually as a "top ten" list. Now, using **The Surveyor** to share the data gives us a vehicle to add value by deepening the analysis. This is presented in separate editions for closely affiliated programs. You can access any of them on our website (achc.org) under Resources and Education/Publications.

As you review the edition or editions most relevant to your setting, you will read examples of actual survey findings. These serve to clarify the specific aspects of the standard that were found to be non-compliant. Following the sample citations, you'll find tips for compliance.

While healthcare is constantly evolving, we are currently emerging from a time of unusually rapid change. Some of the deficiencies cited in the following pages can be traced directly to the impact of COVID-19. Many organizations made significant adjustments to continue to meet the needs of their patient/client populations: adopting new technology for remote visits and patient monitoring; sourcing against PPE shortages; reassigning staff to manage furloughs and quarantines. These are all examples of unanticipated change that required quick action that may have shifted focus away from some areas of required compliance.

Organizations that previously received the HFAP **Quality Review** used it in conjunction with their Deficiency Report (ACHC's Summary of Findings) to compare their performance against peer organizations and to proactively address issues frequently seen in other organizations. Used this way, the data becomes part of the process of continuous quality improvement and on-going survey readiness. We want to help you avoid a series of ramp up activities as your survey approaches by making ACHC Standards part of your overall quality strategy.

As always, ACHC is here as a partner in meeting your accreditation and education needs. Your feedback on this publication and on any aspect of our programs is welcomed and invited.

José Domingos
President & CEO

ACHC's Home Health, Hospice, and Home Infusion Therapy Accreditation Programs offer a comprehensive array of options designed to parallel the specialized services provided by agencies offering this care. All of these services are Medicare-eligible and ACHC holds deeming authority from the Centers for Medicare and Medicaid Services for each of these programs. This distinguishes them from the ACHC Private Duty Accreditation Program designed for agencies that offer care and supportive services that are paid by individuals, Medicaid, or other private insurance.

FROM THE PROGRAM DIRECTOR

Agencies look to ACHC for leadership in establishing and evaluating quality. Identifying frequently-cited deficiencies provides a data-driven review of survey results for a defined period. It gives ACHC-accredited home health, hospice, and home infusion therapy agencies a roadmap for improvement and it guides our efforts to provide relevant, actionable education.

Agencies have seen an increase in patients choosing home health, hospice, and home infusion therapy services over a hospital or nursing home throughout the ongoing public health emergency. Somewhat ironically, the PHE has represented a unique, if unbidden, opportunity to demonstrate the caliber of care that can be provided in the home and virtually by these agencies.

Simultaneously, these provider organizations have experienced staffing shortages. The result has been fewer clinicians taking on the care of more, higher acuity patients.

Frequent Deficiencies

The data in this report reflect deficiencies cited on surveys performed between June 1, 2020, and May 31, 2021. The top deficiencies for this period relate primarily to the elements of the patient record that change most frequently. Deficiencies are often caused by omission or errors that may trace back to the staffing issues created by the PHE. When patient load increases, and especially when clinicians are less experienced, there is a resultant uptick in documentation errors.

A focus on monitoring deficiencies gives us ongoing insight into the kinds of resources agencies need to be successful in achieving and maintaining accreditation. More and more, home health, hospice, and home infusion therapy supplier agencies see improved survey results as they go through the accreditation process multiple times. Each cycle allows for a deeper dive for the ACHC Surveyor and a recalibration opportunity for the organization. Generally speaking, we find that agencies that embrace the concept of accreditation as a framework for continuous quality improvement do improve over time.

ACHC's community-based provider teams continue to look for ways to use customer feedback to enhance our processes and add value. The introduction of virtual surveys developed to meet a need created by the PHE has been welcomed and will continue as an offering for non-deemed programs and distinctions. Similarly, telehealth has improved access to services which has broadened its acceptance by patients and payors. Our team's ability to recognize these services and validate quality is a means of supporting agencies in building their capacity and confidence in this area.

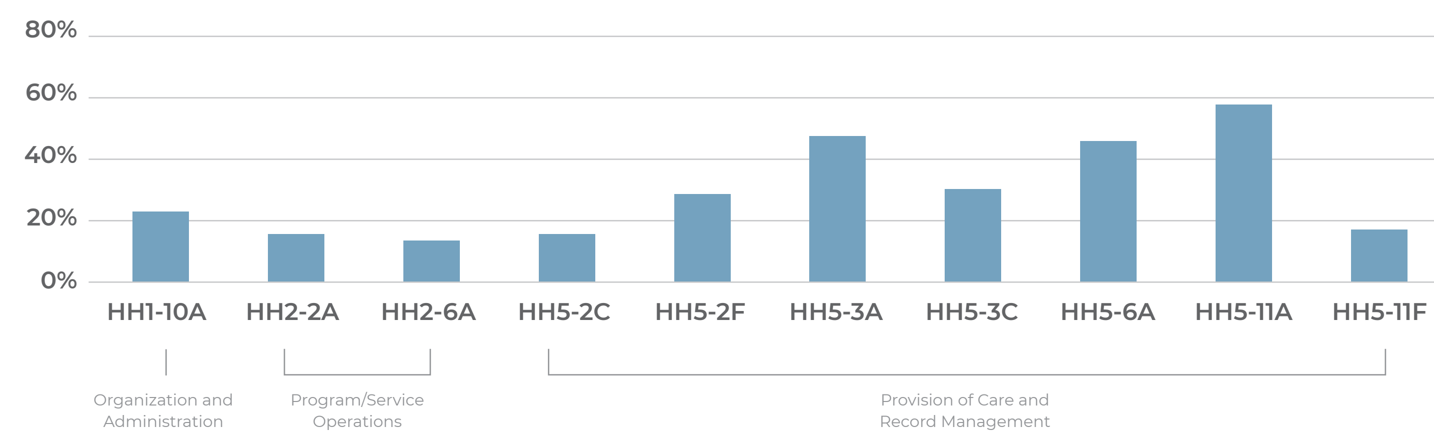
ACHC's focus is always on the individual organization and how it meets the standards in a practical, sustainable way.

ACHC's focus is always on the individual organization and how it meets the standards in a practical, sustainable way. This personal approach is appreciated by provider agencies of all sizes and specialties. I hope you will find the information in this report useful and I look forward to your feedback on its presentation in this format.

Susan Mills, RN

Susan Mills
Senior Program Director

HOME HEALTH DEFICIENCIES



HOME HEALTH SERVICES AND DISTINCTIONS

Services

- Home Health Aide
- Medical Social Services
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Skilled Nursing

Distinctions

- Palliative Care
- Telehealth
- Behavioral Health

ORGANIZATION AND ADMINISTRATION

HH1-10A

Overview of the requirement

The standard ensures that the home health agency (HHA) maintains a written contract/agreement with outside personnel and organizations providing care/services.

Comment on deficiencies

The standard was cited when contracts and agreements were not complete/did not include all relevant elements.

Frequency of citation: 23%

Examples of Surveyor findings

Upon contract review, the following was revealed:

- HHA contracts did not include language relating to the following elements:
  - Denied Medicare or Medicaid enrollment.
  - Exclusion or termination from any federal health care program or Medicaid.
  - Revocation of Medicare or Medicaid billing privileges.
  - Debarment from participating in any government program.
- HHA contracts did not show evidence of a statement discharging the liability of the beneficiary or any other person to pay for the services. Both the agency and the contractor must agree not to charge the patient for covered services and items and to return money incorrectly collected.

Tips for compliance

Review contracts/written agreements to ensure compliance with required components including but not limited to:

- Patients are accepted for care only by the primary HHA.
- The care/services to be furnished.
- The necessity to conform to all applicable HHA policies and procedures, including personnel qualifications, orientation, competencies and required background checks.
- The responsibility for participating in developing plans of care.
- The manner in which care/services will be controlled, coordinated, and evaluated by the HHA.
- The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation.
- The procedures for payment for care/services furnished under the contract.
- Duration of contract/agreement.
- Requirements to meet the Medicare Conditions of Participation.
- Overall responsibility for supervision of personnel.
- Other applicable laws and regulations.
- Liability insurance for individuals providing direct care and HHAs providing shared responsibility of patient care.
- The home health agency is not contracting with an agency, organization, or individual providing services under arrangement that have been:
  - Denied Medicare or Medicaid enrollment.
  - Been excluded or terminated from any federal health care program or Medicaid.
  - Had its Medicare or Medicaid billing privileges revoked.
  - Been debarred from participating in any government program.

PROGRAM/SERVICE OPERATIONS

HH2-2A

Overview of the requirement

The organization must create and distribute a Patients' Rights and Responsibilities statement.

Comment on deficiencies

The standard was cited when organizations failed to maintain or distribute the rights and responsibilities of clients.

Frequency of citation: 17%

Examples of Surveyor findings

Upon review of policy and procedure, the organization:

- Did not establish written policies and procedures regarding the rights and responsibilities of patients.
- Did not discuss and distribute at the time of the admission.
- Did not have a signed Patient Service Agreement for all patients.

Tips for compliance

- Review and revise policy to ensure all required components are captured in the policy and reflected in the Patients' Rights and Responsibilities statement.
- Educate admission staff on the requirement to provide written notice, in a language and manner understandable to the patient and representative (if any), of the Patient Rights and Responsibilities statement and to obtain the patient or legal representative's signature confirming that they have received the notice during the initial evaluation visit, in advance of furnishing care to the patient.

HH2-6A

Overview of the requirement

The standard ensures that policies are established regarding the patient's right to make decisions about their medical care, accept or refuse medical care, including resuscitation and surgical treatment.

Comment on deficiencies

The standard was cited when the organization did not have evidence that the patient was informed of their right to participate in, be informed about, and consent or refuse care in advance of care and during treatment, where appropriate.

Frequency of citation: 13%

Examples of Surveyor findings

- Patient records did not include evidence of the patient being made aware of their right to participate in, be informed about, and consent or refuse care in advance of that care and during treatment or, when appropriate, to make decisions regarding their medical care, resuscitation, and surgical treatment.

Tips for compliance

- Re-educate admission staff on the importance of completing documentation to support patients being informed of their right to participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to:
  - Completion of all assessments.
  - The care to be furnished, based on the comprehensive assessment.
  - Establishing and revising the plan of care.
  - The disciplines that will furnish the care.
  - The frequency of visits.
  - Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits.
  - Any factors that could impact treatment effectiveness.
  - Any changes in the care to be furnished.

PROVISION OF CARE AND RECORD MANAGEMENT

HH5-2C

Overview of the requirement

The standard ensures that organizations establish and implement policies related to the comprehensive assessment being completed within five days of the start of care.

Comment on deficiencies

The standard was cited when comprehensive assessments were not completed within the 5-day time frame or assessments were incomplete and missing sections.

Frequency of citation: 17%

Examples of Surveyor findings

- Comprehensive assessments in patient records were not signed and documented within the required time period.
- Patient records were missing elements/sections of the comprehensive assessment (e.g., Patient Goals and Care Preferences; Financial Assessment; Psychosocial Assessment).

Tips for compliance

- Re-educate appropriate staff on the importance of timely and complete comprehensive assessments.
- Audit medical records to ensure comprehensive assessments are completed within the defined time period.

HH5-2F

Overview of the requirement

The agency must conduct and document a drug regimen review as part of the comprehensive assessment.

Comment on deficiencies

The standard was cited due to incomplete and incorrect drug regimen documentation.

Frequency of citation: 30%

Examples of Surveyor findings

During drug regimen documentation review, the following was observed:

- Documentation did not have evidence of a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions.
- Incorrect and incomplete instructions were entered for medications.

Tips for compliance

- Ensure an ongoing medication review is completed for all patients.
- Ensure all PRN medications identify an indicator for when the medication should be administered.
- Ensure oxygen is listed on the medication profile and includes LPM, route of administration, and whether oxygen is to be administered intermittently or continuously.
- Ensure documentation in the medical record supports notification of the physician or allowed practitioner of any medication discrepancies.

HH5-3A

Overview of the requirement

The standard ensures that each patient receives an individualized written plan of care.

Comment on deficiencies

The standard was cited because plans of care were either not entered, incorrect, or incomplete.

Frequency of citation: 48%

Examples of Surveyor findings

Upon patient record review, the following was observed:

- Patient records missing individualized plans of care.
- Incorrect plans of care (e.g., including an order for oxygen, but the patient is not prescribed oxygen).
- Incomplete plans of care (e.g., not including frequency of medication or PRN modifier; not entering dosage, route, or frequency).

Tips for compliance

- Ensure all patients have an individualized written plan of care that addresses the issues identified in the comprehensive assessment
- Ensure the physician or allowed practitioner is notified to approve any changes or modifications to the original plan of care.
- Ensure all orders for all disciplines include the amount, frequency, and duration of the service provided.
- Ensure all therapy orders include the specific procedures and modalities to be provided.
- Ensure all PRN orders for medications and treatments identify an indicator for the administration of the medication or treatment.
- Ensure all verbal orders are recorded in the plan of care.
- Audit plans of care for accuracy and completion.

HH5-3C

Overview of the requirement

The agency must provide the patient and caregiver with written instructions for the care.

Comment on deficiencies

The standard was cited when written instructions were not provided to the patient and caregiver or because those instructions that were shared were incomplete or inaccurate.

Frequency of citation: 31%

Examples of Surveyor findings

- Agency did not maintain documentation that written instructions were given to the patient and caregiver.
- The instructions did not include the name and contact information of the agency clinical manager.
- The instructions were incomplete (e.g., instructions did not including dosage, frequency of medications).
- Instructions were not written using patient-friendly language.

Tips for compliance

- Ensure that every patient and caregiver is provided written instructions outlining:
  - Visit schedule, including the frequency of visits by HHA personnel and personnel acting on behalf of the HHA.
  - 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.
  - Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.
  - Any other pertinent instruction related to the patient's care and treatments that the HHA will provide.
  - Name and contact information of the HHA clinical manager.
- Audit medical records for documentation that written instructions were provided to the patient and caregiver and are updated to reflect changes in the patient's plan of care.
- Educate visiting staff to ensure the written information provided in the home remains current.

HH5-6A

Overview of the requirement

The standard ensures that the agency develops and implements an effective transfer and discharge planning process for patients who are transferred to another HHA or who are discharged.

Comment on deficiencies

The standard was cited because of lack of documentation to support the discharge or transfer and/or summaries were not provided in timely fashion to the appropriate physician or health-care practitioner.

Frequency of citation: 46%

Examples of Surveyor findings

Upon patient record review, the following was observed:

- Incomplete discharge/transfer summary (e.g., lacking emergency contact and the name of person receiving the report).
- No documentation that a discharge summary was sent to the patient's primary care practitioner or other health care professional who will be overseeing the patient's care after discharge/transfer.
- Notice of Medicare Non-Coverage (NOMNC) was not issued at least 48 hours prior of termination of home health services.

Tips for compliance

- Ensure that a complete discharge or transfer summary is completed and sent to the appropriate recipients;
  - The summary is sent to the primary care practitioner or other health care professional within five business days of the patient's discharge.
  - The transfer summary is sent to the receiving facility within two business days of a planned transfer or two days of becoming aware of an unplanned transfer.

HH5-11A

Overview of the requirement

The standard ensures that professionals providing skilled services to HHA patients, directly or under arrangement, participate in the coordination of care and assume responsibility for:

- Ongoing interdisciplinary assessment of the patient.
- Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s).
- Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care.
- Patient, caregiver, and family counseling.
- Patient and caregiver education.
- Preparing clinical notes.
- Communication with all physicians or allowed practitioners involved in the plan of care, and other health care practitioners (as appropriate) related to the current plan of care.
- Participation in the HHA's QAPI program.
- Participation in HHA-sponsored in-service training.
- Supervision of skilled therapy professional assistants and licensed practical or vocational nurses and social worker assistants.

Comment on deficiencies

The standard was cited when skilled professional services were not provided in accordance with the plan of care, clinical documentation was incorrect and incomplete, or the physician or allowed practitioners involved in the plan of care and other health care practitioners related to the current plan of care were not notified of a change in status.

Frequency of citation: 58%

Examples of Surveyor findings

- Records did not have evidence that skilled professionals assumed responsibility for providing services that are ordered by the physician as indicated in the plan of care.
  - There was no documentation that orders were followed — labs, wound care, medication administration.
  - Care was provided without evidence of an order.
  - Physicians or allowed practitioners were not notified when vitals were outside parameters.
  - Clinical notes did not contain location of wound.

Tips for compliance

- Conduct routine audits of documentation to ensure that care was provided in accordance with the plan of care, documentation is complete and identifies the type of care, service, and treatment provided, and evidence that all physicians or allowed practitioners involved in the plan of care and other health care practitioners (as appropriate) were notified regarding changes in the patient's status.

HH5-11F

Overview of the requirement

Home health aide duties must be defined and implemented into the patient care.

Comment on deficiencies

The standard was cited because of incomplete or inaccurate home health aide written instructions or the home health aide did not provide care in accordance with the written instructions.

Frequency of citation: 18%

Examples of Surveyor findings

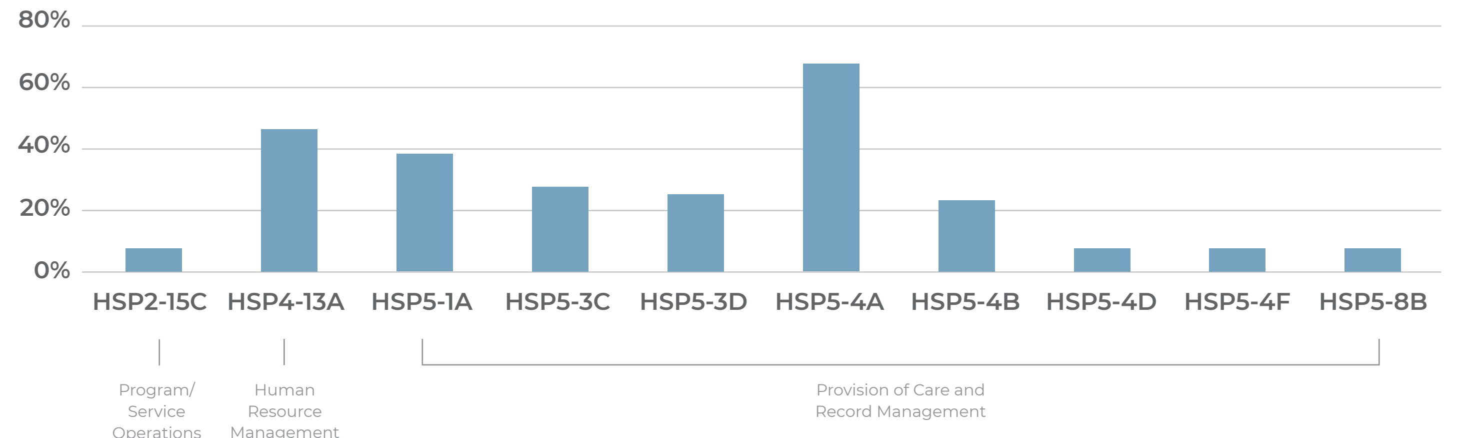
- The home health aide duties developed by a registered nurse (or other qualified skilled professional) did not specify what tasks are to be completed and at what frequency.
- Written instructions were written as PRN, per patient's choice or "completed as needed." However, there was no statement regarding the patient's cognitive and functional ability to make the decision.
- Tasks were not completed/documented as indicated on the aide written instructions (e.g., aides were assigned to weigh the patient at every visit, but weights were not documented every visit).
- The home health aide provided care that was not included on the written instructions (e.g., foot care, skin care, nail care, turn/position).).

Tips for compliance

- Re-educate qualified skilled professionals that aide written instructions must be specific to the task provided and include the frequency with which the task is to be provided. Educate home health aides on the requirement to provide care in accordance with the written instructions and how to properly document patient refusal.
- Audit medical records to ensure the written instructions for aides are specific to the task to be provided and include the frequency in which the task is to be provided.

HOSPICE

HOSPICE DEFICIENCIES



HOSPICE SERVICES AND DISTINCTIONS

Services	Distinctions
Hospice Care	Palliative Care
Hospice Inpatient Carey	Telehealth

PROGRAM/SERVICE OPERATIONS

HSP2-15C

Overview of the requirement

A registered nurse must be designated to ensure the continuous assessment of the patient's and family's needs and to coordinate activities with the interdisciplinary group.

Comment on deficiencies

The standard was cited due to a lack of continuous assessment by the RN.

Frequency of citation: 9%

Examples of Surveyor findings

Patient records lacked:

- Documentation to support the progress of the wound; no documentation of the continuous assessment of the wound.
- Evidence of follow-up for medication effectiveness.
- Documentation of assessment after a fall.
- Documentation after a triage call reporting new symptoms related to disease process.

Tips for compliance

- Re-educate the nursing staff on the importance of documenting progress or lack of progress regarding interventions initiated for newly identified problems and/or long-standing issues or concerns.

HUMAN RESOURCE MANAGEMENT

HSP4-13A

Overview of the requirement

Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for supervision of hospice aides. Hospice aides must provide services that are ordered by the IDG, included in the plan of care, permitted to be performed under state law, and consistent with the hospice aide training.

Comment on deficiencies

The standard was cited because of incorrect or incomplete hospice aide written instructions, failure to provide care in accordance with the written instructions, or failure to notify RN of changes in patient's condition that indicate a need to change the plan of care.

Frequency of citation: 48%

Examples of Surveyor findings

- Hospice aide duties developed by the RN did not specify what tasks were to be completed and at what frequency.
- Written instructions were written as PRN or per patient's choice without indicating the patient was cognitively and functionally able to make the decision.
- Tasks were not completed/documented by the aide as indicated on written instructions (e.g., provide bed bath twice weekly and aide documented bed bath provided 3 times a week).
- A new aide assignment form was not created/updated when aide services were changed.
- Hospice aide did not notify the registered nurse upon observing a catheter leaking urine.

Tips for compliance

- Re-educate RNs that aide written instructions must be specific to the task provided and include the frequency in which the task is to be performed
- Educate hospice aides on the requirement to provide care in accordance with the written instructions and how to properly document a patient refusal.
- Educate hospice aides on what additional patient changes require notification to the RN.
- Audit medical records to ensure the aide's written instructions are specific to the task to be performed and includes the frequency with which the task is to be performed.

PROVISION OF CARE AND RECORD MANAGEMENT

HSP5-1A

Overview of the requirement

The client/patient record must contain legible, clear, complete, and appropriately authenticated and dated documentation of all care/service provided, directly or under contract.

Comment on deficiencies

The standard was cited due to incorrect or incomplete documentation.

Frequency of citation: 39%

Examples of Surveyor findings

Upon patient record review, the following was observed:

- Visit notes were not signed and/or dated by staff.
- Incomplete documentation.
  - Missed visit reports did not include a reason for the missed visit.
- Inconsistent documentation.
  - Notes entered regarding oxygen storage, but the patient is not on oxygen or notes state aide supervision provided but patient is not receiving aide services; hospice medical director's initial certification contained a different primary diagnosis that RN initial assessment visit.
- Use of unapproved abbreviations.
- Missing advance directives.
- Incomplete initial or re-certification of terminal illness.
- Missing physician orders.
  - Discharge order from the hospice Medical Director missing.

Tips for compliance

- Re-educate staff on the importance of correct, consistent, and complete documentation.
- Re-educate staff on agency policy regarding approved abbreviations.
- Re-educate staff on the required content of the hospice medical record including but not limited to:
  - Identifying information
  - Initial plan of care
  - Updated plans of care
  - Initial assessment
  - Comprehensive assessment
  - Updated comprehensive assessments
  - Signed copy of the notice of Patient Rights
  - Signed copy of election statement
  - Response to medications, symptom management, treatments, and services
  - Outcome measure data elements
  - Physician certification and recertification of terminal illness (The initial certification and recertification must meet the requirements set forth in 42 CFR 418.22)
  - Advance directives
  - Physician orders
  - Signed and dated clinical and progress notes
  - All other items required by ACHC standard HSP5-1A.01.

HSP5-3C

Overview of the requirement

The interdisciplinary group must complete the comprehensive assessment within five days after the election of hospice Medicare benefit.

Comment on deficiencies

The standard was cited when elements of the comprehensive assessment were not completed within the required time frame.

Frequency of citation: 27%

Examples of Surveyor findings

The following elements of the comprehensive assessment were not completed within five days of the election of hospice care:

- Spiritual comprehensive assessment.
- Psycho-social assessment.
- Bereavement risk assessment.
- Assessment of the imminence of death.
- Comprehensive pain/physical assessment.

Tips for compliance

- Re-educate RN staff on the time period for completing the comprehensive assessment.
- Audit medical records to ensure comprehensive assessments contain all required elements including but not limited to:
  - The physical, psycho-social, emotional, and spiritual needs of the patient and family.
  - The nature and condition causing admission.
  - Complications and risk factors that affect care planning.
  - Functional status, include the patient's ability to understand and participate in his or her own care.
  - Imminence of death.
  - Severity of symptoms.
  - Bereavement.
  - The need for referrals and further evaluation by appropriate health professionals.

HSP5-3D

Overview of the requirement

An RN creates and maintains a current medication profile and reviews all patient medications.

Comment on deficiencies

The standard was cited because of incorrect and incomplete medication profiles.

Frequency of citation: 25%

Examples of Surveyor findings

Patient record review indicated the following:

- Medication profile did not include all prescribed and over-the-counter medications (e.g., nursing staff documenting that patient was using oxygen, but oxygen was not included in the medication profile).
- Medication profile did not include PRN modifiers.
- Documentation did not include start/stop dates, volume/rate of administration, and drug diluent type.
- Incorrect administration frequency noted in the medication profile.
- Medication profile contained discontinued medications.

Tips for compliance

- Ensure that medication profiles are complete and accurate and contain all prescription and over-the-counter medications.
- Conduct routine audits of medication profiles to maintain accuracy.

HSP5-4A

Overview of the requirement

The agency must develop an individualized, patient-specific written plan of care and must reflect patient/family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments.

Comment on deficiencies

The standard was cited due to incomplete plan of care.

Frequency of citation: 66%

Examples of Surveyor findings

- Plan of care did not contain goals and interventions to manage pain and symptoms related to the primary diagnosis and related conditions.
- Plan of care did not contain all durable medical equipment (DME) patient is using.
- Plan of care did not contain orders for all disciplines providing care to the patient.
- Plan of care contained PRN visits without a quantifier.
- Plan of care contained incomplete treatment and/or medication orders.

Tips for compliance

- Educate staff regarding the requirement to have a complete, individualized patient-specific plan of care that includes but is not limited to:
  - Start of care date
  - Certification period
  - Patient demographics
  - Principle diagnosis and other pertinent diagnoses
  - Medications: dose/frequency/route
  - Allergies
  - Orders for specific hospice services and disciplines, treatments, procedures (specify amount/frequency/duration)
  - Interventions to manage pain and symptoms
  - Equipment and supply needs
  - Family needs
  - Spiritual needs
  - End-of-life care preferences

- Bereavement needs
- Patient goals/outcomes
- Functional limitations
- Diet and nutritional need
- Safety measures
- Audit medical records to ensure the plan of care is individualized to the patient and family.

HSP5-4B

Overview of the requirement

The client/patient record must reflect that care is delivered as per the plan of care.

Comment on deficiencies

The standard was cited when plans of care were not adhered to during provision of care.

Frequency of citation: 24%

Examples of Surveyor findings

Patient record review revealed the following discrepancies:

- Spiritual care provider did not visit as ordered.
- Social worker did not visit as ordered.
- Stitches removed with no evidence of a physician order for the removal.
- Treatments ordered were not provided:
  - Blood samples not drawn as per physician orders.
  - Wound care was not performed as ordered.

Tips for compliance

- Re-educate staff on documenting visits appropriately to validate care was provided in accordance with the plan of care and how to properly document patient refusals.
- Audit medical records to ensure staff are providing care in accordance with the plan of care.

HSP5-4D

Overview of the requirement

A hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/IID representatives.

Comment on deficiencies

The standard was cited when hospice plans of care did not identify the care/services needed and specifically identify which provider was responsible for performing the respective functions.

Frequency of citation: 9%

Examples of Surveyor findings

Upon patient record review, the following was observed:

- Skilled nursing needs like wound care and UTI management did not indicate which provider was to provide care and at what frequency.
- Changes to the hospice plan of care were not discussed with the SNF representatives nor the family.

Tips for compliance

- Re-educate the hospice interdisciplinary group on the plan of care process when developed in conjunction with a SNF/ICF.
- Conduct routine audits of plans of care to ensure completion and accuracy.

HSP5-4F

Overview of the requirement

The hospice interdisciplinary group must revise and document the individualized plan as required, but no less frequently than every 15 calendar days.

Comment on deficiencies

The standard was cited when plans of care were not updated after status changes or medication adjustments.

Frequency of citation: 9%

Examples of Surveyor findings

The following was observed during patient record review:

- Documentation in the medical record indicated a change in the patient's condition and the plan of care was not updated to reflect the change:
  - A DNR was signed, but the POC was not updated to reflect that the patient became a DNR.
  - Plan of care was not updated to include goals and interventions after a medication change.
  - Patient became incontinent, POC was not updated to reflect goals and interventions related to new symptom.
  - Plan of care was not revised to reflect updated services ordered by the physician.

Tips for compliance

- Re-educate nursing staff on best practices for complete and accurate plans of care
- Conduct routine audits of plans of care to ensure completion and accuracy.

HOSPICE

HSP5-8B

Overview of the requirement

Discharge summaries must be completed when patients are discharged from hospice.

Comment on deficiencies

The standard was cited because discharge summaries were either incomplete or not sent to the patient's attending physician.

Frequency of citation: 9%

Examples of Surveyor findings

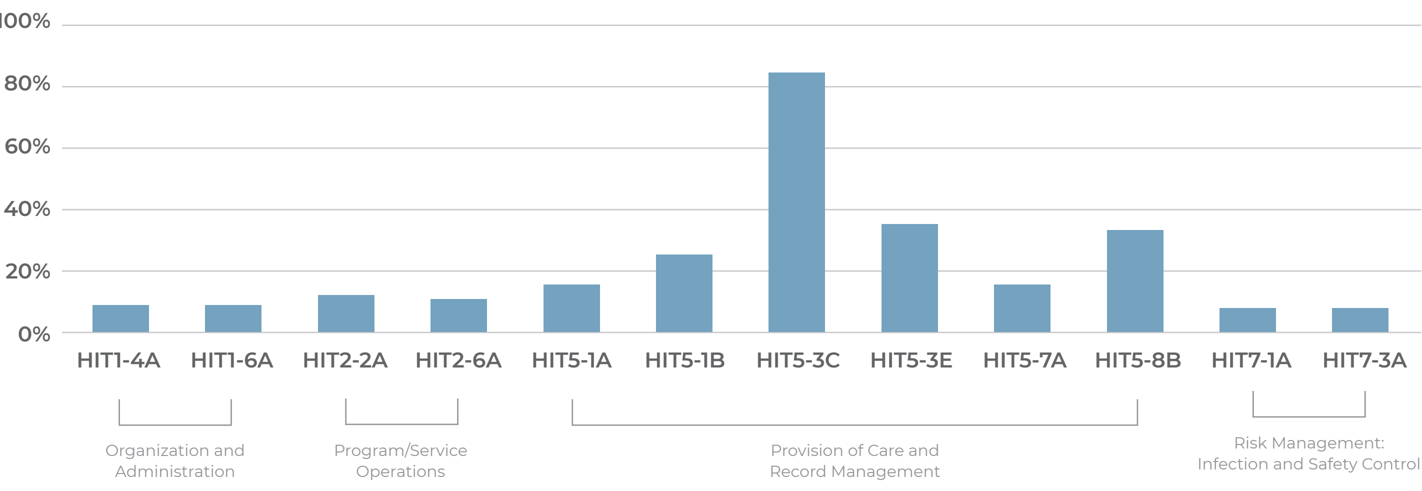
Patient record review revealed the following:

- No evidence that a discharge summary was sent to the patient's attending physician after the patient revoked hospice services.
- Discharge summary did not include the patient's current plan of care or the latest physician orders.
- Discharge summary did not include information related to current plan of care, patient treatments, symptoms, or progress made toward goals.

Tips for compliance

- Review discharge summary policies with the staff to ensure that required elements are completed and documentation exists in the medical record to support that a discharge summary was sent to the attending physician.

HOME INFUSION THERAPY DEFICIENCIES



HOME INFUSION THERAPY

ORGANIZATION AND ADMINISTRATION

HIT1-4A

Overview of the requirement

The standard ensures that there is a designated individual responsible for the overall operation and services of the organization.

Comment on deficiencies

The standard was cited because the responsibilities were not included in the individual's job description or the job description had not been signed.

Frequency of citation: 9%

Examples of Surveyor findings

- Upon personnel record review, it was revealed that there was no evidence that the designated individual had the responsibilities written in the job description.
- It was observed that the organization had not had the individual sign their job description.

Tips for compliance

- Re-educate the HR manager on this standard.
- Audit personnel records to ensure the job description specifies the responsibilities and authority of a manager/leader that is responsible for all of the organization's programs and services and is accountable to the governing body/owner and that the job description is signed.

HIT1-6A

Overview of the requirement

The standard ensures that organizations are in compliance with applicable federal, state, and local regulations.

Comment on deficiencies

The standard was cited because organizations were not in compliance with Medicare/Medicaid regulations or state rules.

Frequency of citation: 9%

Examples of Surveyor findings

Upon observation, the following was observed:

- No evidence that the agency was in compliance with the Medicare and Medicaid regulations regarding a full patient record on file to bill for the services.
- No evidence that the agency had the state-mandated HITS policy as per the rules of the state Board of Nursing.

Tips for compliance

- The agency will need to ensure that the organization is in compliance with all applicable federal, state, and local laws and regulations including but not limited to:
  - Local and state licensure.
  - Professional licensure/certification.
  - The Americans with Disabilities Act.
  - Equal Employment Opportunities Act.
  - Fair Labor Standards Act.
  - Title VI of the Civil Rights Act of 1964.
  - Occupational Safety and Health Administration (OSHA).
  - Medicare and Medicaid regulations.
  - Health Insurance Portability and Accountability Act (HIPAA).
  - Organization policies and procedures.
  - Accreditation Commission for Health Care (ACHC) Accreditation Process.
  - Other laws and regulations as applicable to the care/service provided by the organization.
- Educate responsible staff on this requirement.
- Audit policies and processes to ensure compliance.

PROGRAM/SERVICE OPERATIONS

HIT2-2A

Overview of the requirement

The standard ensures that there are policies and procedures related to the Client/Patient Rights and Responsibilities statement.

Comment on deficiencies

The standard was cited because patients did not receive the written notice of Rights and Responsibilities before the initial visit.

Frequency of citation: 13%

Examples of Surveyor findings

The policy and procedure revealed that "Patient Rights and Responsibilities" were not established by the organizations.

The following was observed during patient record review:

- No evidence of a written notice that the client/patient received the rights and responsibilities before the initial visit.
- Patient received the written notice the day after the initial visit.

Tips for compliance

- Ensure that written policies and procedures are established by the organization in regard to the creation and distribution of the client/patient Rights and Responsibilities statement.
- Ensure there is evidence of a written notice provided to the client/patient in advance of furnishing care/service or during the initial evaluation visit before the initiation of care/service regarding their rights and responsibilities.
- Educate staff on requirement.
- Audit policies and patient records to ensure compliance.

HIT2-6A

Overview of the requirement

Organizations must establish policies and procedures related to the client's/patient's rights to accept or refuse medical care, resuscitation, surgical treatment, and the right to formulate an advance directive.

Comment on deficiencies

The standard was cited because there was no documentation of the patient receiving advance directive information prior to the initiation of care.

Frequency of citation: 10%

Examples of Surveyor findings

Patient record review revealed the following:

- No evidence that advance directive information was provided to the client/patient prior to initiation of care.
- Outdated advanced directive information was distributed to patients.

Tips for compliance

- Ensure there is documentation of the client's/patient's decision regarding an advance directive.
- Ensure that advance directive information is provided to the client/patient prior to the initiation of care/services. Educate staff of the importance of distributing advance directive information prior to initiation of care/services.
- Audit patient records to ensure compliance.

PROVISION OF CARE AND RECORD MANAGEMENT

HIT5-1A

Overview of the requirement

The standard ensures that a record is maintained for each service recipient and that the record contains accurate clinical information.

Comment on deficiencies

The standard was cited because service recipient records were missing relevant and required elements.

Frequency of citation: 10%

Examples of Surveyor findings

Upon review of patient record review, the organization:

- Did not have a complete plan of care for all patients.
- Did not have evidence of all required documentation (e.g., discharge summary, advance directive).

Tips for compliance

- Ensure evidence of a complete plan of care that includes all required elements of the record.
- Educate staff on requirement.
- Conduct patient record audits to ensure compliance.

HIT5-1B

Overview of the requirement

The client/patient record must contact documentation of all care/service provided, directly or by contract.

Comment on deficiencies

The standard was cited due to incorrect or incomplete documentation.

Frequency of citation: 26%

Examples of Surveyor findings

Upon patient record review, the following was observed:

- Incomplete documentation (e.g., missing dosage, frequency of medications).
- Documentation not signed by nursing staff.
- Incorrect documentation (e.g., port access noted, but patient did not have one).
- Nursing notes missing credentials with associated signatures.

Tips for compliance

- Ensure of documentation of all care/service provided, directly or by contract, with entries dated and signed by the appropriate personnel. Educate staff on requirement.
- Audit patient records to ensure compliance.

HIT5-3C

Overview of the requirement

The standard ensures that each patient receives an individualized written plan of care.

Comment on deficiencies

The standard was cited because plans of care were not entered, were incorrect, or were incomplete.

Frequency of citation: 86%

HOME INFUSION THERAPY

Examples of Surveyor findings

Upon patient record review, the following was observed:

- Patient records missing individualized plans of care.
- Incorrect plans of care (e.g., including an order for oxygen, but the patient is not prescribed oxygen).
- Incomplete plans of care (e.g., not including frequency of medication or PRN modifier; not entering dosage, route, or frequency).

Tips for compliance

- Ensure there is evidence of a written plan of care for each client/patient accepted to services that includes all required elements.
- Educate staff on requirement.
- Audit patient records to ensure compliance.

HIT5-3E

Overview of the requirement

The client/patient record must reflect that care is delivered as per the plan of care.

Comment on deficiencies

The standard was cited because plans of care were not adhered to during provision of care.

Frequency of citation: 37%

Examples of Surveyor findings

Patient record review revealed the following discrepancies:

- Incorrect volume of saline used for flush during dressing change.
- Blood drawn peripherally, rather than the PICC line.
- Orders included weekly PICC dressing change; visit notes did not show evidence of PICC dressing change.
- Laboratory tests not conducted at the frequency noted in orders.

Tips for compliance

- Ensure that care is delivered in accordance with the plan of care and is directed at achieving established goals.
- Educate staff on this requirement.
- Audit patient records to ensure compliance.

HIT5-7A

Overview of the requirement

The standard ensures that the agency develops and implements an effective transfer and discharge planning process for patients.

Comment on deficiencies

The standard was cited when discharge/transfer summaries were incomplete or policies were not implemented effectively.

Frequency of citation: 12%

Examples of Surveyor findings

Upon patient record review, the following was observed:

- Transfer summary not completed prior to patient hospitalization.
- Discharge summary did not include a description of needs that could not be met.
- Discharge summary was not completed by pharmacy services
- Documentation did not include a summary of the client's/patient's response to therapy (e.g., progress toward clinical goals)

Tips for compliance

- The agency will need to ensure that discharge/transfer summary report, a notation in the progress notes, or a software section dedicated to discharge/transfer that includes but is not limited to:
  - A summary of the services provided.
  - Client's/patient's response to therapy (e.g., progress toward clinical goals).
  - The date and reason for the discharge/transfer.
  - A brief description of ongoing needs that could not be met.
  - Any instructions or referral information given to the client/patient.
- Educate staff on requirement.
- Audit patient records to ensure compliance.

HIT5-8B

Overview of the requirement

A licensed skilled professional must review and document all medications.

Comment on deficiencies

The standard was cited because of incorrect and incomplete medication profiles.

Frequency of citation: 35%

Examples of Surveyor findings

Patient record review indicated the following:

- Medication profile did not include all prescribed medications.
- Medication profile did not include PRN modifiers.
- Documentation did not include start/stop dates, volume/rate of administration, and drug diluent type.
- Incorrect frequency noted in the medication profile.

Tips for compliance

- Ensure that medication profiles are complete and accurate, as per physician's orders.
- Audit patient records to ensure compliance. Educate staff on requirement

RISK MANAGEMENT: INFECTION AND SAFETY CONTROL

HIT7-1A

Overview of the requirement

The agency must maintain and document an infection control program to protect patients and personnel from infections and communicable diseases.

Comment on deficiencies

The standard was cited because infection control measures and best practices were not exercised.

Frequency of citation: 9%

Examples of Surveyor findings

Upon observation, the agency did not demonstrate appropriate infection control measures and appropriate cleaning procedures, as evidenced by the following observations:

- Nursing staff did not perform correct handwashing practices before starting the patient's IV.
- No evidence of a TB Exposure Control Plan.
- TB Exposure Control plan did not include a current organization assessment indicating the prevalence rate of TB in the communities serviced by the organization as well as the TB rate of the patients serviced by the organization.

Tips for compliance

- Ensure that all personnel demonstrate infection control procedures in the process of providing care/service to patients as described in OSHA and CDC standards and as adopted into program care/service policies and procedures.
- Conduct visits with staff to ensure compliance.
- Develop and implement a TB Exposure Control Plan.
- Ensure the TB Exposure Control plan includes a current organization assessment indicating the prevalence rate of TB in the communities serviced by the organization as well as the TB rate of the patients serviced by the organization.
- Review plan annually and update to reflect significant modification in tasks or procedures that may result in occupational exposure.
- Educate staff on requirement.

HIT7-3A

Overview of the requirement

The standard ensures that organizations have a complete disaster/crisis responses plan in place.

Comment on deficiencies

The standard was cited because organization's emergency plans were incomplete or not adequate to meet the patients' needs.

Frequency of citation: 9%

Examples of Surveyor findings

- Medical records revealed no patient emergency plans included in the documentation.
- Policies did not include an Emergency Plan outlining alternative methods for care, mobilizing resources, and time frames for plan initiation.
- Disaster Drill logs did not show annual practice drills.

Tips for compliance

- The agency will need to ensure that written policies and procedures are established by the organization that outline the process for meeting client/patient needs in a disaster or crisis situation. The process includes:
  - A system to identify alternative methods for contacting personnel.
  - Mobilizing resources to meet critical needs.
  - Alternative methods, resources, and travel options for the provision of care/service.
  - Safety of personnel.
  - Identified time frames for initiation of the plan.
  - Specific measures for anticipated emergencies typical or appropriate for the geographical area served (e.g., hurricanes, tornadoes, floods, earthquakes, chemical spills, and inclement weather).
  - Clients/patients identified and prioritized based upon their need so that care/service is ensured for clients/patients whose health and safety might be at risk.
- The organization educates all personnel about the process to meet patient needs in a disaster or crisis situation.
- The organization has, at a minimum, an annual practice drill to evaluate the adequacy of its plan.
- The emergency plan also describes access to 911 Emergency Medical Services (EMS) in the event of needed emergency care/services for clients/patients and personnel.
- Ensure there is evidence client/patient education regarding emergency preparedness to include:
  - Evacuation plans.
  - Medications.
  - Food/water.
  - Important documents.
  - Care for pets, if applicable.
- Educate staff on requirement.
- Audit emergency plan, disaster drill logs and patient records to ensure compliance.

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