

**CHHA Survey Investigation Worksheet 1: Clinical Record Review/Home Visit
DRAFT 2-8-18; REVISED 7/5/18**

Agency Name: _____ Survey Date: _____ Surveyor Name: _____

Patient Name/Confidential ID#: _____ Referral Date: _____ SOC: _____

Primary/Secondary Diagnoses: _____

Discipline(s) ordered: (circle): SN PT OT SLP MSW Aide Discipline observed during HV (circle): RN LPN PT PTA OTA COTA SLP MSW SW asst Aide

Attach copies of current plan of care, medication profile, & subsequent orders, ADL & IADL, Assessment/OASIS items, Aide care plan (if applicable) and any other documentation related to findings.

REFER TO DRAFT CoPs FOR HOME HEALTH AGENCIES INTERPRETIVE GUIDELINES 1-13-18

CoPs and Related G Tags- Level 1 and 2 Tags (Level 1 tags in bold)	Interpretive Guidance Probes	Comments (Indicate if determined by RR or HV)
<p><i>484.50 Condition: Patient Rights (G406)</i> Level 1 Standards: -G434 Participate in care -G476 Investigation of Complaints -G478 Investigate complaints made by pt. -G480 Treatment or care -G482 Mistreatment, neglect or abuse -G484 Document complaint and resolution G-486 Protect patient during investigation G488 Immediate reporting of abuse by all staff</p> <p>Level 2 Standards -G438 Confidential clinical record Other: G408, G410, G412, G414, G416, G418, G420, G422, G424, G426, G428, G430, G432, G436, G440, G442, G444, G446, G448, G450, G452, G454, G456, G458, G460, G462, G464, G466, G468, G470, G472, G474, G490.</p>	<p><u>IG:</u> -evidence that patient was informed about care, assess, POC, discipline, frequency of visits, changes -patient informed how to lodge complaint - agency has policy/system to record, track and investigates complaints -documentation of complaint and resolution -staff report pt abuse, mistreatment, injuries of unknown source, misappropriation of property</p> <p>Home Visit Probes: <input type="checkbox"/> Ask patient/caregivers if they have had any complaints and how they pursued them. Was it resolved to their satisfaction? <input type="checkbox"/> Ask if patient/caregiver were able to participate in planning care.</p>	

CoPs and Related G Tags- Level 1 and 2 tags (Level 1 tags in bold)	Interpretive Guidance Probes	Comments (Indicate if determined by RR or HV)
<p><i>484.55 Condition: Comprehensive Assessment of Pts.(G510)</i></p> <p>Level 1 Standards:</p> <ul style="list-style-type: none"> -G512 Initial assessment visit -G514 RN performs assessment -G518 Completion of the comprehensive assessment -G520 5 Calendar days after start of care -G522 Eligibility for Medicare home health benefit -G524 Therapy services determine eligibility -G536 A review of all current medications -G544 Update of comprehensive assessment -G548 Within 48 hours of patient's return <p>Level 2 Standards:</p> <ul style="list-style-type: none"> -G546 Last 5 days of every 60 days except for transfer/discharge -G550 At discharge <p>Other: G516, G526, G528, G530, G532, G534, G538, G540, G542</p>	<p><u>IG:</u></p> <ul style="list-style-type: none"> -initial assessment within 48 hours and not acceptable to request a different SOD date from MD for purposes of complying or agency convenience. -RN must conduct except therapy only cases -Comp assessment must be completed within 5 days of SOC -comp assessment accurately reflects patient's status -update assessment including OASIS items every 60 days - assessment within 48 hours of inpatient or on physician ordered start of care date -med review all meds pt currently taking to identify adverse effects, drug reactions/interactions, side effects, duplicate drug therapy, non compliance <p>Tag 0017 EP Requirement: Comprehensive assessment includes an individualized emergency plan in the event of an emergency.</p>	
<p><i>484.60 Condition: Care Planning, Coordination, Quality of Care (G570)</i></p> <p>Level 1 Standards:</p> <ul style="list-style-type: none"> -G572 Plan of Care -G574 Plan of care must include the following -G578 Conformance with physician orders -G580 Only as ordered by a physician -G582 Influenza and pneumococcal vaccines <p>Level 2 Standards:</p> <ul style="list-style-type: none"> -G586 Standard: Review and revision of the POC -G588 Reviewed, revised by physician every 60 days <p>G590 Promptly alert relevant physician of changes</p> <p>Other: G576, 584, G592, G594, G596, 598, G600, G602, G604, G606, G608, G610, G612, G614, G616, G618, G620, G622</p>	<p><u>IG:</u></p> <ul style="list-style-type: none"> - Individualized POC includes outcomes/goals - POC signed by MD - treatments only per MD orders - POC includes pertinent dx, mental, psychosocial, cognitive status, types of services, equipment, supplies required, freq and duration of visits, prognosis, rehab potential, functional limitations, activities permitted, nutritional requirements., medication, tx, safety measures to protect ag injury, description of patient' s risk for ED visits, hospital readmission, and nec interventions to address risk factors, patient specific interventions and education, measurable outcomes and goals, info related to advanced directives, any additional items. - MD notification changes in condition or needs that suggest outcomes not being achieved/or POC should be altered. 	

CoPs and Related G Tags- Level 1 and 2 tags (Level 1 tags in bold)	Interpretive Guidance Probes	Comments (Indicate if determined by RR or HV)
<p><i>484.75 Condition: Skilled professional services (G700)</i></p> <p>Level 1 Standards:</p> <ul style="list-style-type: none"> -G704 Standard: Responsibilities of skilled professionals -G706 Interdisciplinary assessment of the patient -G708 Development and evaluation of POC -G710 Provide services in the POC -G712 Patient, caregiver, and family counseling -G714 Patient and caregiver education -G716 Preparing clinical notes G718 Communication with physicians <p>Level 2 Standards:</p> <ul style="list-style-type: none"> -G724 Standard: Supervise skilled professional assistants -G726 Nursing services supervised by RN -G728 Rehab services supervised by PT, OT -G730 Medical social services supervised by MSW <p>Other: G702, G720, G722</p>	<p><u>IG:</u></p> <ul style="list-style-type: none"> -skilled prof responsible for ongoing interdisciplinary assessment - dev POC in partnership with pt/family/others - provides services per POC & MD orders -provides pt/family counseling, education -communications with all physicians involved in the POC 	
<p><i>484.80 Condition: Home Health Aide Services (G750)</i></p> <p>Level 1 Standards:</p> <ul style="list-style-type: none"> -G798 HHA assignments and duties -G808 Onsite supervisory visit every 14 days <p>Level 2 Standards:</p> <ul style="list-style-type: none"> -G768 Competency evaluation -G774 12 hours in-service every 12 months -G800 Services provided by HH aide -G802 Duties of a HH aide -G814 Non-skilled direct observation every 60 days -G820 HH aide services under arrangement <p>Other: G752, G754, G756, G758, G760, G762, G764, G766, G770, G772, G776, G778, G780, G782, G784, G786, G788, G790, G792, G794, G796, G804, G806, G810, G812, G816, G818, G822, G824, G826, G828</p>	<p><u>IG:</u></p> <ul style="list-style-type: none"> -aide assigned by RN/Therapist -written instructions (aide care plan) -onsite supervision visit every 14 days <p>Level 2:</p> <ul style="list-style-type: none"> - aides trained/certified -12 hours inservice training - home health aide services ordered by MD, included in POC, consistent with training and aide scope of tasks -aides under contract ensure certified, quality of care provided, supervision 	

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<p>484.105 Condition: Organization and administration of services</p> <p>Level 1 Standard:</p> <p>-G984 Standard: All services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice.</p>	<p><u>IG:</u></p> <p>The CHHA must offer skilled nursing services and at least one other therapeutic service. One service must be provided directly.</p> <p>-verify direct service & document on CMS Form 1572</p> <p>-cite if care not provided in accordance with current clinical practice, infection control guidelines, State Practice Acts, etc.</p>	
<p>484.110 Condition: Clinical records (G1008)</p> <p>Level 1 Standards:</p> <p>-G1010 Standard: Contents of clinical record</p> <p>-G1012 Required items in clinical record</p> <p>-G1014 Interventions and patient response</p> <p>-G1016 Goals in the patient's plan of care</p> <p>Level 2 Standards</p> <p>-G1028 Standard: Protection of record</p> <p>Other: G1018, G1020, G1022, G1024, G1026, G1030</p>	<p><u>IG:</u></p> <p>-clinical record includes current assessments, all assessments from most recent home health admission, clinical notes, POCs, MD orders</p> <p>-all interventions, treatments, services, medications administration, goals and progress toward goals</p> <p>-HIPAA compliant</p>	