Ready for Survey!

Keys and Strategies for SUCCESS!

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Summer 2023

Surveyors are Here?!

Prepping for Survey?

Where and HOW do you even START?!

Take-Aways from this Session

- Implement tools for survey preparation and a survey manual
- Learn how to do a self-assessment
- Know the top national citations from 2022- and how to avoid them

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Steps taken to go from Conditional Survey to SUCCESSFUL Survey

- Be informed!
  - Join state associations and organizations like HHF!
  - Subscribe to trade emails/listservs
  - Sign up for CMS home health specific listservs
  - Monitor your MAC news- what are they looking for

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Steps taken to go from Conditional Survey to SUCCESSFUL Survey

And from the inside:

- Educate team on the deficiencies and policy/practice going forward
- Daily workflow of oversights in EMR
- Have an EMR optimization visit onsite
- Pulling CMS data from iQIES and PEPPER
- Internal audits and outside audits at least quarterly
- Ensure every SOC/ROC and DC are QA'd per Manage OASIS Task
- Developed process to generate the updated POC
- Ensured CMS and state were notified of change in leadership

Avoid the Panic Button with PREPARATION

How to Organize your Survey Prep

- EVERYONE is involved in Prep OVER Panic!
- Ringcards or Cheat sheets and Practice for EVERYONE!
  - KNOW your current COVID protocols for your agency and follow

  - 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.

How to Organize your Survey Prep

- IT Designee/EMR Champion
  - 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

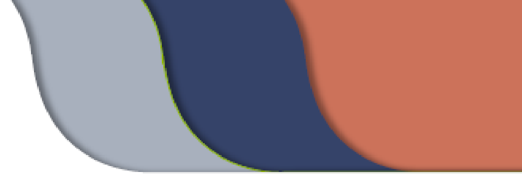
- Field Clinicians
  - Reminders on Bag technique (never on floor-unless wheeled, clean hands before entering bag, zip close after removing all of clean equipment, clean equipment before returning to bag
  - Reminders of common infection control issues (clean hands after touching computer keys/screen/phone, clean hands in between glove changes, change gloves and clean hands between wounds when more than one)
  - Medication reconciliation must-dos!
  - DME (a special favorite of our state surveyors!) in the home that the patient uses

Survey Binder- the BEST Tool for Prep

- See example of 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 Table of Contents
  - List of employees/contractors
  - If Deemed status with an accrediting organization (Joint Commission, CHAP/ACHC), then include CASPER reports
- When survey is close- consider running reports each Monday morning to be “extra prepared”
  - See list of reports on Table of Contents
- ALSO: Be sure to have your Emergency Preparedness Binder, Infection Control/Surveillance, QAPI Binders updated and handy!

Survey Binder-Specific Reports and Information

SURVEY PREPARATION GUIDE



Prepared By: Provider Insights, LLC

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.)

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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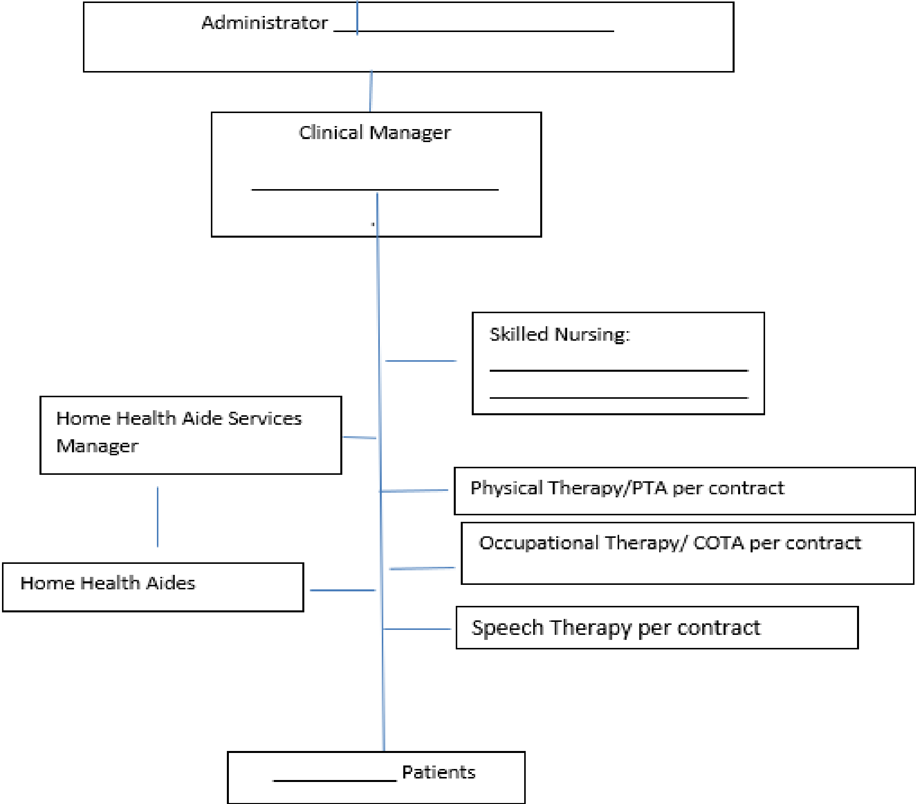
Survey Organizational Chart-Administrator to Patient



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Self-Assessment Time!
Let’s Unpack the “Real Rules”

Preparation for Survey

- Know the rules
  - Conditions of participation, State regs, Accrediting Organizations' standards, Your policies
- Know how you meet the rules
- How are we ensuring the rules are met ongoing?
- Having access to the test before you have to take it! (Self-Assessment!)

Level One- Blue, Level Two- Green, Extended Survey-White

484.50(e)(1)(iii)	G486	Protect patient during investigation
484.50(e)(2)	G488	Immediate reporting of abuse by all staff
484.50(f)(1,2)	G490	Standard: Accessibility
484.55	***G510***	***Condition: Comprehensive Assessment of Patients***
484.55(a)	G512	Standard: Initial assessment visit.
484.55(a)(1)	G514	RN performs assessment
484.55(a)(2)	G516	Skilled professional performs assessment
484.55(b)	G518	Standard: Completion of the comprehensive assessment
484.55(b)(1)	G520	5 calendar days after start of care
484.55(b)(2)	G522	Eligibility for Medicare home health benefit
484.55(b)(3)	G524	Therapy services determine eligibility
484.55(c)	G526	Standard: Content of the comprehensive assessment
484.55(c)(1)	G528	Health, psychosocial, functional, cognition
484.55(c)(2)	G530	Strengths, goals, and care preferences
484.55(c)(3)	G532	Continuing need for home care
484.55(c)(4)	G534	Patient's needs
484.55(c)(5)	G536	A review of all current medications
484.55(c)(6)	G538	Primary caregiver(s), if any
484.55(c)(7)	G540	The patient's representative (if any);
484.55(c)(8)	G542	Incorporate OASIS items
484.55(d)	G544	Standard: Update of the comprehensive assessment
484.55(d)(1)	G546	Last 5 days of every 60 days unless:
484.55(d)(2)	G548	Within 48 hours of the patient's return
484.55(d)(3)	G550	At discharge
484.60	***G570***	***Condition: Care planning, coordination, quality of care***
484.60(a)(1)	G572	Standard: Plan of care
484.60(a)(2)	G574	Plan of care must include the following
484.60(a)(3)	G576	All orders recorded in plan of care
484.60(b)	G578	Standard: Conformance with physician orders
484.60(b)(1)	G580	Only as ordered by a physician
484.60(b)(2)	G582	Influenza and pneumococcal vaccines
484.60(b)(3)(4)	G584	Verbal orders
484.60(c)	G586	Standard: Review and revision of the plan of care
484.60(c)(1)	G588	Reviewed, revised by physician every 60 days
484.60(c)(1)	G590	Promptly alert relevant physician of changes

Mock Survey Time!

Start with your agency's top issues in the past, and then focus on the national "top citations" from surveys

Assessment and Strategy

Pre-Survey Assessment	
Tier 1 Potentially Avoidable Events:	
• Emergent Care for Hypo/Hyperglycemia or Meds	
OBQI Report:	
• Any 10% lower than Reference Outcome(s) noted ___	
Patient/Agency Characteristics Report:	
• Are there any Dx >15% Reference?	
Dx noted_	
Submission Statistics by Agency:	
• <20% error reject rate?	
Error Summary Report by HHA:	
Entrance Interview	
• Organizational structure clear	
• Ability to provide patient reports (including current census, unduplicated census and schedules)	
• Access to medical records	

Mock Survey Checklist

M= Met, N= Not Met, NA= Not assessed/applicable

	484.50	***G406***	***Condition: Patient rights***	
M	484.50(a)(1)(i)	G412	Written notice of patient's rights	
	484.50(a)(1)(ii)	G414	HHA administrator contact information	
	484.50(a)(3)	G420	Verbal notice of rights and responsibilities	
	484.50(c)(4)	G434	Participate in care	
	484.50(c)(5)	G436	Receive all services in plan of care	
	484.50(c)(6)	G438	Have a confidential clinical record	
	484.50(c)(7)	G440	Payment from federally funded programs	
	484.50(c)(8)	G442	Written notice for non-covered care	
	484.50(c)(9)	G444	State toll free HH telephone hotline	
	484.50(c)(10)	G446	Contact info Federal/State-funded entities	
	484.50(c)(11)	G448	Freedom from discrimination or reprisal	
	484.50(c)(12)	G450	Access to auxiliary aids and language service	
	484.50(d)	G452	Standard: Transfer and discharge	
	484.50(d)(1)	G454	HHA can no longer meet the patient's needs	
	484.50(d)(2)	G456	Patient/payer will no longer pay for services	
	484.50(d)(3)	G458	Outcomes/goals have been achieved	
	484.50(d)(4)	G460	Patient refuses services	
	484.50(e)(1)	G476	Standard: Investigation of complaints	
	484.50(e)(1)(i)	G478	Investigate complaints made by patient	
	484.50(e)(1)(i)(A)	G480	Treatment or care	
	484.50(e)(1)(i)(B)	G482	Mistreatment, neglect or abuse	
	484.50(e)(1)(ii)	G484	Document complaint and resolution	
	484.50(e)(1)(iii)	G486	Protect patient during investigation	
	484.50(e)(2)	G488	Immediate reporting of abuse by all staff	
	484.55	***G510***	***Condition: Comprehensive Assessment of Patients***	
	484.55(a)	G512	Standard: Initial assessment visit.	
	484.55(a)(1)	G514	RN performs assessment	Met
	484.55(a)(2)	G516	Skilled professional performs assessment	

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G0572	*Plan of care*	1		
G0578	*Conformance with physician orders*	2		
G0710	*Provide services in the plan of care*	3		
G0590	Promptly alert relevant physician of changes	4		
G0580	Only as ordered by a physician	5		
G0574	*Plan of care must include the following*	*6*		
G1022	Discharge and transfer summaries	7		
G0682	Infection Prevention	8		
E0004	Develop EP Plan, Review and Update	9		
G0570	Care planning, coordination, quality of care	10		

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G0572: Plan of Care

- “Individualized” patient specific goals (big area for surveyors!)
- POC periodically reviewed (i.e. every 60 days or more frequently. . .)
  - Signed by MD, DO, DPM (in specific cases), new guidance allows NP, or PA
- General referral from physician vs. actual POC components
- Missed visits and/or treatments

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Service Plan	Status
1: 12/05/22 - 02/02/23	
Care Plan	
Care Need: Patient Stated Goal	In Progr...
Goal : Patient stated goal: I want my wound...	In Progr...
Care Need: Promotion of Wound Healing	In Progr...
Goal : Wound will show evidence of healing ...	In Progr...
Assess Wound for Nursing	In Progr...
Assess Infection for Nursing	In Progr...
Teach Wound Care:Closed drainage devices f...	In Progr...
Teach Equipment:Wound V.A.C. for Nursing	In Progr...
Teach Diet:Wound healing-Diet and wound h...	In Progr...
Teach Disease Process:Diabetes: Type 2-Fo...	In Progr...
Teach Skin Care:Signs and symptoms of infe...	In Progr...
Pain Overview Assessment for Nursing	In Progr...
Wound Procedure-RBKA for Nursing	In Progr...
Goal : Client will verbalize blood glucose re...	In Progr...
Assess Glucose Monitoring for Nursing	In Progr...
Assess Diet for Nursing	In Progr...

Goal: Wound will show evidence of healing by a reductio...

Goal Category

Predefined Goal User Defined

Goal Type

* **Goal Text** Wound will show evidence of healing by a reduction in size by 75% and no s/sx infection, and client will verbalize s/sx infection by 9 weeks (2/2/23).

* **Goal Status** In Progress

Print for These Resource Classes

Nursing

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◀◀ Choose Patient ○ Patient Overview ○ Task Notes ○ Patient Status ● Orders ○ Medications ○ Lab Results ○ Care Plan ○ Patient Schedule ○ Resource Plan ▶▶

Visit (1) | Procedure (1) | Health Management (4) | PRN | Service | Medication (18) | Order Set (2)

Create New Order | View Health Mgmt Order History | PRNs? | Plan Period 1: 12/05/22 - 02/02/23

Received Order On	Resource Class/Creds	Type	Instance	Start Date	End Date	Update	Discontinue
12/05/22 08:00 by Amy Palmer		Physician Notification	Best Practice, VS parame...	12/05/22	02/02/23	Update	Discontinue
12/05/22 08:00 by Amy Palmer		Physician Notification	Hospitalization risks	12/05/22	02/02/23	Update	Discontinue
12/05/22 08:00 by Amy Palmer		Physician Notification	Psychosocial Risks	12/05/22	02/02/23	Update	Discontinue
01/11/23 15:36 by Amy Palmer		Physician Notification	Unable to perform visits	01/11/23	02/02/23	Update	Discontinue

01/11/23 15:36 Health Management Order: Physician Notification - Unable to perform visits

View Orders For Session

Order Text

Health Management Order: Physician Notification - Unable to perform visits
Client canceled 2 of 3 visits this week. Spouse has been applying betadine and moist gauze to RBKA wound site. Plan to resume visits as scheduled on Friday, 1/13/23.
Start Date: 01/11/23, End Date: 02/02/23

Session Information

Ordered By: Lowry, Timothy
Send for Signature: Yes

Received By	Amy Palmer
Received How	Written
Session Created By	Amy Palmer
Physician Branch	Main

Session History | Edit Session

Supplies and DME

Description	Ord Qty

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G0574: Plan of Care Contents

- 484.60 lists all of the POC components we are accustomed to on the 485, with three additions added when the COPS were updated in 2018
  - Advanced directives
  - Risk for re-hospitalization, and interventions to negate risks
  - Psychosocial status
- “DME” still biggest culprit of this issue! Surveyors will “find” additional DME while in home visits that is not on POC

Built Order Set with Additional POC Info

8. Date of Birth [redacted] | 9. Sex ☒ M ☐ F

11. ICD	Principal Diagnosis <See 487>	Date
T87.43	Infection of amputation stump, right	112722(O)
12. ICD	Surgical Procedure	Date
N/A	N/A	N/A
13. ICD	Other Pertinent Diagnoses <See 487>	Date
L03.119	Cellulitis of unspecified part of limb	112722(O)

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

Florastor; 250 mg; oral; capsule; 1 Capsule AM and PM
Novolog Flexpen U-100 Insulin; 100 unit/mL (3 mL); subcutaneous; insulin pen; 25 Units under the skin AM, Noon, and PM with meals.; Instructions: Inject 3 additional units for every 50 greater than 150mg/dL Max 90 units daily. Client injects self.
Senna Lax; 8.6 mg; oral; tablet; 1 Tablet every 12 hours as needed for constipation.
Tresiba FlexTouch U-200; 200 unit/mL (3 mL); subcutaneous; insulin pen; 0.25 mL every PM; Instructions: 0.25mL=50 units.

14. DME and Supplies
Walker, wheelchair, medi boxes, sharps container, wound vac

15. Safety Measures
911, Ambulation with Wheelchair, Ambulation with walker, Animal Safety,

16. Nutritional Req. Diabetic

17. Allergies NKDA

18.A. Functional Limitations

- 1 ☒ Amputation
- 2 ☐ Bowel/Bladder (Incontinence)
- 3 ☐ Contracture
- 4 ☐ Hearing
- 5 ☐ Paralysis
- 6 ☐ Endurance
- 7 ☒ Ambulation
- 8 ☐ Speech
- 9 ☐ Legally Blind
- A ☐ Dyspnea With Minimal Exertion
- B ☒ Other (Specify) <See 487>

18.B. Activities Permitted

- 1 ☐ Complete Bedrest
- 2 ☐ Bedrest BRP
- 3 ☒ Up As Tolerated
- 4 ☐ Transfer Bed/Chair
- 5 ☐ Exercise Prescribed
- 6 ☐ Partial Weight Bearing
- 7 ☐ Independent At Home
- 8 ☐ Crutches
- 9 ☐ Cane
- A ☒ Wheelchair
- B ☒ Walker
- C ☐ No Restrictions
- D ☐ Other (Specify)

19. Mental Status:

- 1 ☒ Oriented
- 2 ☐ Comatose
- 3 ☐ Forgetful
- 4 ☒ Depressed
- 5 ☐ Disoriented
- 6 ☐ Lethargic
- 7 ☒ Agitated
- 8 ☒ Other <See 487>

20. Prognosis:

- 1 ☐ Poor
- 2 ☐ Guarded
- 3 ☐ Fair
- 4 ☒ Good
- 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) <See 487>

Advanced Directives: Full Code
Health Management Order(s):
• Physician Notification Psychosocial Risks - Effective: 12/05/22 - 02/02/23 Psychosocial risk factors: taking psychotropics, taking antipsychotics, history of lack of follow through on medical advice, patient does not have current involvement in community or support groups, diagnosis of depression
• Physician Notification Hospitalization risks - Effective: 12/05/22 - 02/02/23 Hospitalization Risk Factors: More than one hospitalization or ER visit in past 12 months, More than 5 secondary dx, History of Falls, Discharged from Hospital, Diabetes, ADL assistance needed
• Physician Notification Best Practice, VS parameters - Effective: 12/05/22 - 02/02/23 A plan of care has been confirmed with physician, agreeable to agency policy on VS parameters: Temperature <96.0 F or > 100.4 F Pulse < 50 or > 110 beats/minute Respirations < 6 or > 35 per minute Blood Pressure < 80/50 or > 180/100. SAO2 < 88%, as well as Best Practices measures Diabetic Foot Care, Fall Prevention, Depression Intervention, Pain Intervention

22. Goals/Rehabilitation Potential/Discharge Plans

Goal #1: Patient stated goal: I want my wound closed and healed so I can get my prosthetic.
Goal #2: Wound will show evidence of healing by a reduction in size by 75% and no s/sx infection, and client will verbalize s/sx infection by 9 weeks (2/2/23).
Goal #3: Client will verbalize blood glucose readings within his normal range (85-160) x 9 weeks (02/02/2023).
Rehabilitation Potential: Good

23. Nurse's Signature and Date of Verbal SOC Where Applicable: | 25. Date HHA Received Signed POT

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Other POC Top 10!

- G0578- Conformance with Physician Orders
  - Have to follow the order AS written- so careful how you write!
- G0710- Provide services in the POC
- These citations are all about emphasizing that home health is a physician/NP/PA driven health care entity– The HHA can't just "run the show" The HHA must show documentation proving the communications with the provider

G0590: Promptly Alert Relevant Dr of Changes

- Cited routinely when there are changes in condition noted in narrative documentation, but no documentation the relevant ordering provider was notified
- Do you use “parameters” for notification?
  - Do you ask the provider to CHANGE the parameter when it isn’t fitting the patient need?
- This tag is sometimes cited with missed visits (along with following POC tags)

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Patient Specific Parameters

- Physician Notification Best Practice, VS parameters - Effective: 12/05/22 - 02/02/23 A plan of care has been confimed with physician, agreeable to agency policy on VS parameters: Temperature <96.0 F or > 100.4 F Pulse < 50 or > 110 beats/minute Respirations < 6 or > 35 per minute Blood Pressure < 80/50 or > 180/100. SAO2 < 88%, as well as Best Practices measures Diabetic Foot Care, Fall Prevention, Depression Intervention, Pain Intervention

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G1022: Summaries to Physician

HOW do you SHOW this was completed?

- 484.110(a)(6)(i)- A completed discharge summary **must be sent within 5 business days** to the primary care practitioner or any other health care professionals who will be responsible for providing care and services to the patient after discharge from the agency.
- 484.110(a)(6)(ii)- A completed transfer summary **must be sent within 2 business days** of a planned transfer if the patient's care will be immediately continued in a healthcare facility.
- 484.110(a)(6)(iii)- A completed transfer summary **must be sent within 2 business days** of the agency's knowledge of an unplanned transfer if the patient is still receiving care in a health care facility at the time the agency becomes aware of the transfer.

- Overarching content recommended in interpretive guidelines- but your policy can tell what should be included
- MUST include medications (Transfer of Health Information measure)

DC and TRF Summaries

Summary Notes:

SN visit for D/C from HCS on 12/02/22. 102 yr old admitted on 10/07/22 with acute bronchitis post covid, SVT, hypertension, benign prostatic hyperplasia, and hx of hairy cell leukemia. Alert and oriented. VSS. Lung sounds cl. Abdomen soft with bowel sounds. No edema. Up with walker and steady gait. SN has been seeing pt weekly. HCA 1 x wk for personal cares. Pt is showering on own without difficulty. Has been working with PT and goals are met. Spouse is thinking about assisted living in the future. No longer homebound. D/C HCS.

Signature: Rebecca Mayse RN 12/03/22 15:37

Clinician Signature

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DC Summary Tracking Example

Plan Period 1: 10/07/22 - 12/02/22

- Service Period
  - 1: 10/07/22 - 12/02/22
    - Aide (Discharge)
      - Visits
        - Planned (8)
        - Authorized (0)
        - Performed (7)
        - Unreconciled (0)
        - Remaining (0)
        - Missed/Rescheduled (1/0)
        - PRN (0 remaining)
    - Nursing A (Discharge)
      - Visits
        - Planned (9)
        - Authorized (0)
        - Performed (9)
        - Unreconciled (0)
        - Remaining (0)
        - Missed/Rescheduled (0/1)
        - PRN (0 remaining)
    - Physical Therapy (Discharge)
      - Visits

Admitting Resource Class: Nursing
* Primary Resource Class: Nursing

Plan Period 1: 10/07/22 - 12/02/22

Plan of Care | Tracked Orders | Face-to-Face | Tracked Summary Reports

Tracked Summary Reports for Plan Period 1

Type of Summary Report	Physician	Track #	Status	View
Discharge	Linkenmeyer, Kathryn	00102181	Received	View
Discharge	Mehlhaus, Brian	00102813	Received	View

Tracking Start Date: 12/03/22 15:37
Status Changed: 12/07/22 14:48
Changed By: Sunstrom, Lisa

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G0536: Review of All Current Medications

- **Drug Regimen Review-** A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
- Must account for what was assessed- not just checkbox
- Every comprehensive assessment or with medication additions
- **9/5/18 Final IG: In rehabilitation therapy only cases, the patient's therapist *must* submit a list of patient medications, which the therapist *must* collect during the comprehensive assessment, to an agency RN for review. The agency should contact the physician if indicated.**
- **9/5/18 Final IG: The patient's clinical record should identify all prescription and non-prescription medications taken by the patient, including *times of administration* and route.**
- **11/2018 CMS answered question regarding "times" and did confirm that "A.M", "Bedtime" would be adequate and HHA s do not need to have "8:00a.m."**

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Med Profile

PreserVision AREDS-2; 250-90-40-1 mg; oral; capsule; 1 Capsule two times a day in morning and evening
Systane (PF); 0.4-0.3 %; ophthalmic (eye); dropperette; 1 Drop two times a day in morning and evening to both eyes; Instructions: Clt administers drops
albuterol sulfate; 90 mcg/actuation; inhalation; HFA aerosol inhaler; 1 Inhalation as needed every 6 hours for wheezing
carvedilol; 12.5 mg; oral; tablet; 1 Tablet daily in morning
hydrocodone-acetaminophen; 5-325 mg; oral; tablet; 1-2 Tablets as needed every 4 hours for moderate pain; Instructions: 2 tabs= 10-650mg Do not exceed more than 4,000mg in 24 hours in combination with acetaminophen.
hydroxyzine HCl; 25 mg; oral; tablet; 1 Tablet daily in morning
levothyroxine; 100 mcg; oral; tablet; 1 Tablet daily in morning; Instructions: Take 30 minutes before eating breakfast
losartan-hydrochlorothiazide; 50-12.5 mg; oral; tablet; 1 Tablet daily in morning
pantoprazole; 40 mg; oral; tablet,delayed release (DR/EC); 1 Tablet daily in morning
simvastatin; 40 mg; oral; tablet; 1 Tablet daily at bedtime
warfarin; 2.5 mg; oral; tablet; 1 Tablet daily in evening

G0682: Infection Prevention

- Six (6) standard precautions, identified by the Center for Disease Control and Prevention (CDC) Healthcare Infection Control Practices Committee (HICPAC), which apply during any episode of patient care:

1. Hand Hygiene;
2. Environmental Cleaning and Disinfection;
3. Injection and Medication Safety;
4. Appropriate Use of Personal Protective Equipment;
5. Minimizing Potential Exposures; and
6. Reprocessing of reusable medical equipment between each patient and when soiled.

G0682: Infection Prevention

- Typically, this is cited with a home visit if hand hygiene or bag technique is flawed.
- Area to make priority – devices such as phones, laptops, telehealth monitors, etc.
- Cleaning of equipment/bag in conjunction with policy
- Use the checklist to ensure policies, training, documentation of communications

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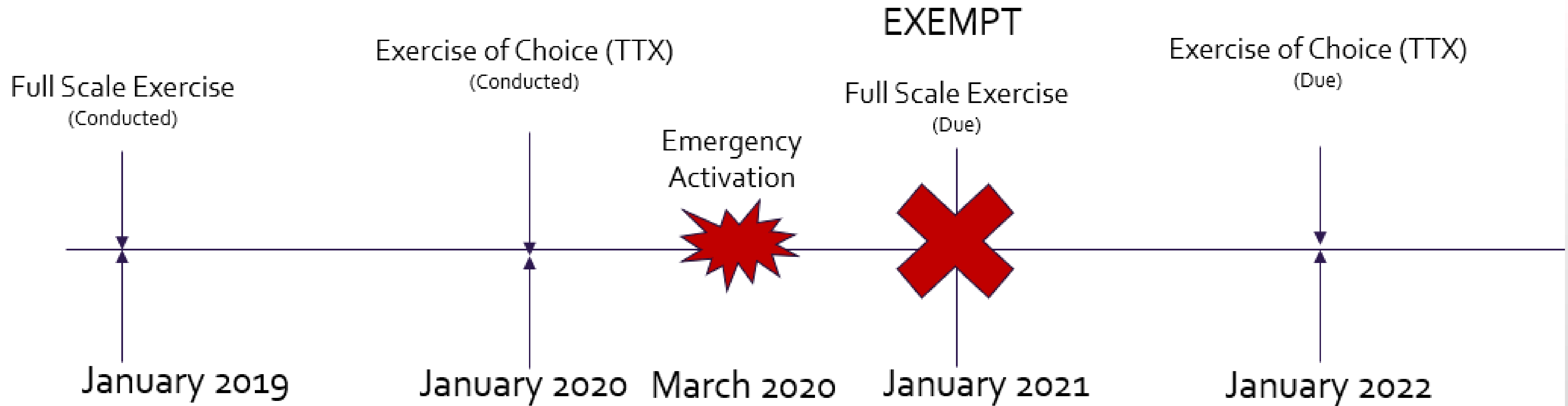
The “E-Tags”

- Cross-setting Emergency Planning since 2017
- Updated Interpretive Guidelines (Appendix Z) March 26th, 2021 for EIDs
- https://www.cms.gov/files/document/qso-20-41-all-revised-05262022.pdfA
- Focus during PHE (and ongoing!)
- See “EXEMPTIONs” in the QSO to see when your next drill is due!
- Top citations
  - E0004: Develop EP Plan and update
  - **E0039: EP Testing Requirements**
- Other Emergency Planning citations
  - Patient’s emergency plan developed and updated/reviewed each comprehensive assessment
  - Agency has communication plan to reach both staff and patients

Actual Emergency Can take Place of Full Scale

Still must do “Exercise of Choice” (table top) on opposite year



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Patient Emergency Plan

- Completed at the SOC, reassessed with each comprehensive assessment by the clinician, in conjunction with the patient/CGs

MY EMERGENCY PLAN CHECKLIST

Your Home Health agency wants to help support you in case of an emergency. Below is an emergency plan we developed during our assessment, with your input. Please contact us if you have questions or changes.

TORNADO??

- ☐ I will go to the basement!
- ☐ I will go to an interior room/closet ________ and stay away from windows and doors
- ☐ I will go to my storm shelter located ___________________________
- ☐ I will shelter under heavy furniture and cover my head

FIRE

- ☐ I will leave my home and meet at designated area_____________________________
- ☐ I will not stop to collect valuables or possessions
- ☐ I will call 911, or ask someone else to call 911 after I am outside of the home

ICE STORM/WINTER STORM

- ☐ I will stay inside my home and use my Disaster Kit (water, food, flashlight, batteries)
- ☐ I will call my emergency contact if I have needs in the home
- ☐ If I lose electricity, I will contact my home health nurse, as well as my emergency

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Document the EP review each assessment

Assess Disaster Preparedness

Note: Discussed disaster preparedness plan with pt and there is a copy in the home.

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What About Your Own?

- Now that you conquered the national top dozen– look back to ensure you are not missing anything based on your last survey

Questions?

- **Annette Lee RN MS, HCS-D, COS-C**
- **Zuzana Ton, MHSA**

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Contact Us

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