CHAP

TOP 10 HOME HEALTH DEFICIENCIES

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	Standard	CFR	Standard Content	Tips For Compliance
1	PCC.2.I.M1	484.50(c)(7-8)(10)	Patient Rights related to the provision of written information.	Does the patient right document include all required elements and do audits reflect that staff include written information specific to the patient and organization that might need to be entered by the clinician.
2	APC.7.I.M2	484.60(a)(2)	Required elements of the Plan of Care.	Elements most missed: measurable goals; over-the-counter medications; interventions to be done on the visit; comorbidity diagnosis.
3	APC.8.I.M3	484.60(e)(1-2)	Provision of written visit schedule, medication schedule.	Have a process for providing patients with a written schedule that is understandable to them. Understandable medication information should provide a current list of medications, dosage, frequency, route and who administers.
4	CDT.7.I.M2	484.75(b)(3)	Skilled Professionals follow the plan of care.	Care provided during visits must comply with the plan of care or additional orders are obtained prior to changing care interventions.
5	CDT.7.I.M7	484.80(g)(2)	Aides not following the plan of care.	Supervisory visits should evaluate that the aide is providing care as per the plan of care through review of documentation and interview of the patient/caregiver.
6	APC.6.I.M1	484.55(c)(5)	Review of Medications as a component of the comprehensive assessment.	Medication reviews are often missed when medications are added. Reviews often do not include over-the-counter medications that the patient is taking.
7	IPC.3.I.M1	484.70(a)	Infection control – hand hygiene and bag technique.	Conduct onsite visits to validate the ability of staff to comply with infection control processes.
8	APC.7.I.M7	484.60(a)(1)	Plan of care includes measurable patient specific goals and physician input for evaluation after the SOC.	Focused audits to review for goals for each discipline on the plan of care. Therapy evaluations initiated after the start of care should reflect physician coordination.
9	PCC.3.I.M3	484.50(a)(2)	Timely provision of rights and responsibilities/transfer and discharge policies to a patient-selected representative.	Documentation reflects the presence of patient selected representative. Agencies must have a process to facilitate the timely provision of information as the patient desires.
10	APC.9.I.M3	484.60(c)(1)	Alerting physician of changes in the patient's condition or needs.	All patient condition changes and/or patient needs are to be communicated to the physician. Documentation of the communication and any resulting care changes validates the action. Medication/treatment changes are often not addressed properly.