TOP 10 **HOME HEALTH** DEFICIENCIES COMPARISON

The chart below includes the top ten CHAP home health survey deficiencies ranked 1-10 by Standard and GTag for the last three calendar years.

Ranking (1-10)	CY 2025	CY 2024	CY 2023
1.	**Standard: APC.10; GTag: G574** Content of the individualized plan of care	**Standard: APC.10; GTag: G574** Content of the individualized plan of care	**Standard: APC.10; GTag: G574** Content of the individualized plan of care
2.	**Standard: APC.14; GTag: G614** The organization provides the patient and caregiver(s) with a copy of written instructions including a visit schedule, including frequency of visits by HHA personnel and contractors	**Standard: APC.14; GTag: G614** The organization provides the patient and caregiver(s) with a copy of written instructions including a visit schedule, including frequency of visits by HHA personnel and contractors	**Standard: APC.14; GTag: G614** The organization provides the patient and caregiver(s) with a copy of written instructions including a visit schedule, including frequency of visits by HHA personnel and contractors
3.	**Standard: APC.23; GTag: G1022** Clinical record includes transfer and/or discharge summaries within the required time frame with evidence of date sent	**Standard: APC.23; GTag: G1022** Clinical record includes transfer and/or discharge summaries within the required time frame with evidence of date sent	**Standard: APC.10; GTag: G576** Each patient will have an individualized plan of care that includes all elements included in the standard.
4.	**Standard: PCC.2; GTag: G442** Patients have the right to receive written notice in advance of care being furnished, if there is possibility of not-covered care, or in advance of reducing or terminating ongoing care	**Standard: APC.8; GTag: G536** The comprehensive assessment includes a medication regimen review	**Standard: APC.14; GTag: G612** The organization provides the patient and caregiver(s) with a copy of written instructions outlining all elements included in the standard.
5.	**Standard: APC.8; GTag: G536** The comprehensive assessment includes a medication regimen review	**Standard: PCC.2; GTag: G442** Patients have the right to receive written notice in advance of care being furnished, if there is possibility of not-covered care, or in advance of reducing or terminating ongoing care	**Standard: APC.23; GTag: G1022** Clinical record includes transfer and/or discharge summaries within the required time frame with evidence of date sent
6.	**Standard: CDT.9; GTag: G710** Skilled professionals follow plan of care including following physician orders	**Standard: CDT.9; GTag: G710** Skilled professionals follow plan of care including following physician orders	**Standard: APC.8; GTag: G536** The comprehensive assessment includes a medication regimen review

Ranking (1-10)	CY 2025	CY 2024	CY 2023
7.	**Standard: IPC.8; GTag: G682** Bags used to carry equipment or supplies into patient's homes follows agency's policy to prevent the spread of infections and communicable diseases	**Standard: IPC.6; GTag: G682** Hand hygiene performed when indicated	**Standard: PCC.2; GTag: G442** Patients have the right to receive written notice in advance of care being furnished, if there is possibility of not-covered care, or in advance of reducing or terminating ongoing care.
8.	**Standard: IPC.6; GTag: G682** Hand hygiene performed when indicated	**Standard: IPC.8; GTag: G682** Bags used to carry equipment or supplies into patient's homes follows agency's policy to prevent the spread of infections and communicable diseases	**Standard: CDT.9; GTag: G710** Skilled professionals follow plan of care including following physician orders
9.	**Standard: APC.12; GTag: G572** The individualized plan of care is periodically reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the home health organization as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start-of-care date	**Standard: IM.17; GTag: G1012** IPC.12 - The organization properly stores and disposes of medical waste products and contaminated syringes used by its personnel in the performance of care and services. Storage and disposal of medical waste products is done in accordance with local, state, and federal law and regulation.	**Standard: APC.23; GTag: G1022** Clinical record includes transfer and/or discharge summaries within the required time frame with evidence of date sent
10.	**Standard: CDT.15; GTag: G808** If home health aide services are provided to a patient, a registered nurse or other appropriately skilled professional must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days.	**Standard: APC.4; GTag: G514** The organization conducts an initial assessment visit by a registered nurse to determine the immediate care and support needs of the patient and to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment is conducted: 1. Within 48 hours of referral; or 2. Within 48 hours of the patient's return home; or on the physician or allowed practitioner ordered start-of-care date	**Standard: APC.8; GTag: G536** The comprehensive assessment includes a medication regimen review

Home Health Deficiency 3-year Trend Analysis

Strong Stability at the Top (Rankings 1–2)

Across all three years, the top two citations remain identical.

Rank	CY 2025	CY 2024	CY 2023
1	APC.10 – content of the individualized plan of care	Same	Same
2	APC.14 – Written instructions & site visit schedule	Same	Same

Interpretation:

- These two standards are persistent, systemic vulnerabilities.
- They relate to care planning and communication of the plan, which are foundational to home health compliance.
- The lack of improvement suggests:
  - Documentation processes may be inconsistent.
  - Staff may not be fully trained or supported.
  - Templates or EMR workflows may not enforce required elements.

These should be considered priority areas for quality improvement, as they consistently drive survey risk.

Mid-Tier Rankings Show Some Movement (Ranks 3–6)

Rank 3

- 2025 & 2024: APC.23 – Transfer/discharge summaries
- 2023: APC.10 (G576) – Individualized plan of care elements

Interpretation:

Transfer/discharge documentation has become a more prominent issue in the last two years. This may reflect:

- Gaps in timely communication with physicians or facilities
- EMR workflow issues around discharge documentation

Ranks 4–6

These positions rotate among:

- PCC.2 – Advance written notice of care changes
- APC.8 – Medication regimen review
- APC.23 – Transfer/discharge summaries
- CDT.9 – Following physician orders

Interpretation:
These mid-tier issues represent operational consistency problems rather than systemic failures. They tend to fluctuate based on:

- Staff turnover
- Surveyor emphasis
- Changes in patient acuity
- Documentation habits

Medication regimen review (APC.8) appears in all three years, indicating a moderate but persistent vulnerability.

Infection Control Standards Move Around (Ranks 7–8)

Standards involved:

- IPC.8 – Bag technique
- IPC.6 – Hand hygiene

Trend:

- These two standards swap positions between years, but both remain in the lower half of the top 10.

Interpretation:

- Infection control compliance is inconsistent but not catastrophic.
- These findings often reflect:
- Observational lapses during home visits
- Variability in staff adherence
- Documentation gaps in infection control policies

Given the regulatory environment, even small lapses can have outsized consequences.

Lower Rankings (9–10) Show the Most Variation

Rank 9:

- 2025: APC.12 – Periodic review of plan of care
- 2024: IM.17 – Medical waste disposal
- 2023: APC.23 – Transfer/discharge summaries

Rank 10:

- 2025: CDT.15 – Supervisory assessments of HHAs
- 2024: APC.4 – Initial assessment timing
- 2023: APC.8 – Medication regimen review

Interpretation:
These lower-ranked issues tend to be:

- Operational compliance issues (supervision, waste disposal)
- Timing-based standards (initial assessment, supervisory visits)
- Documentation-dependent standards

Overall Interpretation

- Across CY 2023–2025, the rankings reveal a clear and consistent pattern: the organization's most significant compliance vulnerabilities are rooted in care planning, communication of care instructions, and documentation reliability. These issues appear at the top of the list every year, that may signal system-level gaps.
- The middle of the rankings shows recurring challenges with timeliness and completeness of required documentation, especially around medication reviews and transfer/discharge summaries. These reflect workflow inconsistencies and processes that are not fully standardized or monitored.
- The lower half of the rankings fluctuate more dramatically, suggesting episodic operational lapses influenced by staffing changes, surveyor focus, or the specific patient sample reviewed. Infection control findings remain present but stable, indicating behavior-based compliance issues rather than structural failures.
- Taken together, the data paints a picture of an organization that performs inconsistently in areas requiring precise, repeatable documentation and communication, while more episodic operational issues rise and fall year to year.
- The stability of the top findings highlights where the most meaningful and lasting quality improvement efforts should be concentrated: strengthening plan-of-care processes, improving documentation workflows, and ensuring consistent communication with patients and caregivers.