TOP NJ HCSF DEFICIENCIES-2025

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CHAP Community Health Accreditation Partner

	Standard	Standard Content
1	NJAC.13	Client record components.
2	NJHR.2	The Health Care Service Firm (HCSF) requires the following personnel information prior to hire: 1. Reference checks; 2. Health reports as required by New Jersey state law and regulation; 3. Criminal background checks per New Jersey law and regulation; 4. Proof of citizenship (I-9 form); 5. Evidence of a competency evaluation; Evidence of current certification as a homemaker-home health aide.
3	NJAC.4	The Health Care Practitioner Supervisor reviews the plan of care not less than once each 30-day period and more often if the client's care changes, condition, or needs of the client change, or other regulatory standards require otherwise.
4	NJAC.4	The Health Care Practitioner Supervisor reviews the plan of care not less than once each 30-day period, and more often if: 1. The circumstances of the client's care changes; 2. The condition and needs of the client changes; or 3. Another specific regulatory standard requires otherwise.
5	NJAC.8	The Health Care Practitioner Supervisor must make an on-site, in-home evaluation of the plan of care not less than once during each 60-day period that the Health Care Service Firm (HCSF) has placed a health care practitioner to provide care/services. The documentation of this 60-day evaluation and whether or not the plan of care needs revision is included in HCSF policy and maintained in the client record.
6	NJPS.2	There is a plan of care for clients receiving skilled healthcare professional services from an employee of a Health Care Service Firm (HCSF), and is developed by an appropriate healthcare professional, in consultation with the client and includes the components in the standard. The written plan of care is signed and dated by the physician and is updated and reviewed at least every two months by physician, or as often as the client's condition requires.
7	NJAC.11	The certified homemaker-home health aide only performs tasks: 1. That are evaluated/delegated by the Health Care Practitioner Supervisor/RN; OR 2. As directed by the Health Care Practitioner Supervisor
8	NJIP.2	The HCSF staff use "standard precautions" while providing care, including hand hygiene, use of gloves, safe handling of equipment likely to be contaminated with body fluids, soiled items, sharp devices and other requirements per state law and regulation.
9	NJIP.4	The Health Care Service Firm (HCSF) shall protect the confidentiality of client and personnel information, whether stored in paper or electronic format.

		• The HCSF shall ensure personnel can only access client or personnel information necessary for their job responsibilities. • The HCSF shall maintain safeguards to protect the confidentiality, integrity, and availability of electronic information. • The HCSF shall have policies and procedures addressing: 1. Collection, use, and disclosure of client information; 2. Protection of client information; 3. Access to client and personnel information; 4. Maintenance and security of client and personnel information. • The HCSF shall ensure the confidentiality of all verbal communications regarding client care and services.

Standard Domain Deficiency Analysis, Key Actions, and Performance Improvement Focus

The following is a structured analysis of the standards deficiencies organized into major domains. It identifies what each item is intended to accomplish and highlighted system-level issues these actions address. This gives you a clear, professional-quality evaluation suitable for Quality Assessment Performance Improvement (QAPI), compliance reviews, or internal performance improvement planning.

Documentation & Record Management

Analysis	Key Actions	Performance Improvement Planning
Intended purpose of the standard Accurate, complete, and timely documentation is foundational to regulatory compliance, continuity of care, risk mitigation, and defensible clinical practice. Deficiencies in documentation often signal deeper system issues such as inadequate training, inconsistent oversight, or unclear expectations. System-level issues for evaluation • Lack of standardized documentation processes. • Inconsistent staff understanding of regulatory documentation requirements. • Missing assessments, service plans, or supervisory notes. • Delayed documentation. • Inconsistent record structure across staff. • Insufficient oversight or feedback loops for documentation errors.	• Perform audits of client records to validate all components of the standard are present. • Educate staff on documentation requirements and proper entries in the client record. • Conduct periodic record reviews to ensure plan-of-care review every 30 days or more frequently with condition changes. • Educate staff about documentation standards at orientation and ongoing. • Ensure plan of care for skilled services meets all requirements. • Conduct audits to validate tasks assigned are appropriate and documented as performed.	• Develop a standardized documentation checklist aligned with regulatory requirements. • Implement monthly documentation audits with scoring and trend analysis. • Provide targeted remediation for staff with repeated documentation deficiencies. • Integrate documentation competency validation into annual skills review. • Audit for consistent completion of assessments, service plans, and supervisory notes. • Use audit findings to refine policies, templates, and workflows.

- Fragmented communication between clinical and administrative staff.

Plan of Care (POC) Management & Care Coordination

Analysis	Key Actions	Performance Improvement Planning

Intended purpose of the standard
The plan of care is the central clinical roadmap for client services, including skilled services that are developed by an appropriate healthcare professional. Deficiencies in POC review, delegation, and adherence create risks for unmet needs, inappropriate care, and regulatory noncompliance.
 	
System-level issues for evaluation
• Lack of structured interdisciplinary communication.
• Inconsistent POC updates when client condition changes.
• Gaps in delegation clarity between RNs and Aides.
• Insufficient supervisory oversight in the field.
• Missing physician signatures.
• Plans not updated every two months.
• Incomplete plan content.
	• Perform periodic record reviews to ensure POC review at least every 30 days.
	• Perform periodic record reviews to ensure in-home evaluation every 60 days with documented evaluation findings.
	• Educate Aides on following the POC and reporting changes to the RN.
	• Educate RNs on collaboration with Aides and revising the POC as needed.
	• Conduct client record audits to ensure Aides follow the POC as assigned.
	• Perform home supervisory visits to observe Aide adherence to the POC.
	• Ensure plan of care for skilled services
	  ○ Includes all required components.
	  ○ Signed and dated by the physician.
	  ○ Reviewed and updated at least every two months or as condition requires.
		• Implement a standardized POC review workflow with automated reminders.
		• Create a structured RN–Aide communication protocol for reporting changes.
		• Develop supervisory visit tools that include POC adherence validation.
		• Track POC revision timeliness as a quality indicator.
		• Provide case-based training on POC updates and delegation.
		• Audit client records for missed 60-day visits, incomplete documentation, and/or no evidence of plan-of-care revision consideration.
		• Audit client records for missed 30-day reviews.
		• Audit client records to assess compliance with skilled plan of care requirements.

Client Rights & Regulatory Compliance

Analysis	Key Actions	Performance Improvement Planning
Intended purpose of the standard Client rights are a core regulatory requirement and a cornerstone of ethical care. Failure to provide required materials or protect rights and confidentiality exposes	• Educate staff that all clients must receive a Client Bill of Rights and CHHA Guide within 24 hours of start of care. • Ensure all staff promote and protect the	• Implement a standardized “Client Rights Packet” with a required signature page. • Add rights verification to the start-of-care checklist.

the organization to compliance risk and undermines client trust.
 	
System-level issues for evaluation
• Inconsistent onboarding processes for new clients.
• Lack of staff awareness of regulatory requirements.
• Absence of verification mechanisms for rights distribution.
• Staff accessing records outside their role.
• Weak password or access controls.
• Missing or inadequate confidentiality policies.
• Insecure storage of paper records.
	exercise of client rights.
	• Conduct audits to ensure compliance with rights-related requirements.
	• Protect confidentiality of all client and personnel information.
	• Limit access to information based on job role.
	• Maintain safeguards for electronic information.
	• Policies must address:
	  ○ Collection, use, disclosure
	  ○ Protection
	  ○ Access
	  ○ Security
		• Conduct quarterly audits of client rights documentation.
		• Integrate client rights education into orientation and annual training.
		• Review policies at least annually and revise as appropriate.

Delegation, Competency, & Staff Role Clarity

Analysis	Key Actions	Performance Improvement Planning
Intended purpose of the standard Clear delegation and role-appropriate task performance are essential for safe care delivery. Deficiencies in this domain often reflect inadequate training, unclear expectations, or weak supervisory oversight. System-level issues for evaluation • Role confusion between licensed and unlicensed staff. • Inconsistent delegation practices. • Lack of structured competency validation.	• Educate Aides on performing tasks only as delegated or directed an RN supervisor. • Educate Aides on following the POC and communicating with the RN. • Educate RNs on collaboration with Aides and revising the POC. • Conduct supervisory visits to validate task performance.	• Develop a delegation protocol outlining allowable tasks. • Implement competency checklists for Aides with annual validation. • Provide RN training on effective delegation and supervision. • Track incidents of task-related noncompliance for trend analysis.

Infection Prevention & Standard Precautions

Analysis	Key Actions	Performance Improvement Planning
Intended purpose of the standard Infection control is a high-risk domain. Field staff must demonstrate consistent competency in standard precautions	• Conduct ongoing education and training related to standard precautions. • Conduct routine field observation visits to	• Implement quarterly infection control refresher training. • Use standardized observation tools

to protect clients and themselves.

System-level issues for assessment

- Inconsistent infection control practices in the field.
- Lack of competency validation beyond initial orientation.
- Limited real-time observation of staff performance.

validate compliance through return demonstration.

during field visits.

- Track infection control deficiencies and provide targeted retraining.
- Incorporate infection control performance into annual evaluations.

Cross-Cutting Themes Across All Domains

1. **Need for Standardization**

   Across documentation, POC management, client rights, and infection control, the organization lacks consistent processes, checklists, and verification mechanisms

2. **Staff Education & Competency Gaps**

   Recurrent need for education suggests:

   - Orientation may be insufficient
   - Ongoing training is not reinforced
   - Competency validation is inconsistent

3. **Insufficient Oversight & Feedback Loops**

   Multiple domains require:

   - More frequent audits
   - Structured supervisory visits
   - Clearer communication channels between field staff and supervisors

4. **Communication & Coordination Challenges**

   Breakdowns between RNs, Aides, and administrative staff affect:

   - POC updates.
   - Documentation accuracy
   - Delegation clarity

5. **Compliance Risk Exposure**

   Deficiencies across domains indicate systemic vulnerabilities that could lead to:

   - Survey citations.
   - Client safety risks

6. **Documentation Integrity**

   Accurate and timely completion of client records, supervisory visits, plans of care, personnel files

7. **Information Security & Confidentiality**

   HIPAA-aligned safeguards must protect:

   - Client information
   - Personnel information
   - Verbal communications