Any questions: 305-818-5940 / 786-514-9352
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SKILLED AGENCY

Survey Common Questions

Initial Survey

Supervision

SERVICE	SUPERVISION
Any skilled service (RN, Therapy) + HHA	HHA supervised **Q14D** (every 14 days)
RN opens the case, RPT follow-up visits by LPN, PTA, OTA, STA	Supervised **Q30D** (every 30 days)
Non-skilled service (Personal Care, Homemaker, etc.)	HHA supervised **Q60D** (every 60 days)

Emergency Management

Patient education starts from the 1st day: on Admission, Sign Up day.

- The Admission RN will categorize the patient within 3 main categories (D1, D2, D3). (Please see the Emergency Plan form in the Admission package sample; category explanation on the back of the form.)
- **D1:** patient whose life depends on the service, lives alone, no caregiver. Example: insulin dependent patient with tremors, blind. These are **HIGH RISK** patients and need to go to a special needs shelter or hospital where the service can continue during the emergency.
- **D2:** same patient, their life depends on the service, but during the emergency has a trained caregiver who can take care of the patient (normally for work or distance cannot). **Medium Risk** patients.
- **D3: Low Risk** patient whose service can safely be placed on hold until the emergency situation is stable and streets are safe for work and services. Example: non-skilled care, some physical therapy services, etc.
- Explain that the Agency will maintain a prioritized hard copy list (remember: during a hurricane there is no electricity, computer or internet service) of all active patients by category (D1-D2-D3), with a copy of each patient's Emergency Plan form, Plan of Care, Medications and Shelter Registration attached to the list.
- If the patient needs to go to a shelter (D1 patients), the Agency must help the patient register in the shelter by contacting the DOH Special Needs Registration in the county of the patient's place of residence (data needed is at the end of the CEMP Manual for each county where the Agency is licensed). The doctor must be informed of the Shelter Registration application (usually electronic), and the Agency must share the registration with the MD.
- The Agency must maintain proof of CEMP submission to the DOH and the approval letter (annually).
- Agency staff must educate the patient about emergencies and what to do in an emergency (stay at home, with family, go to a hospital or shelter). Data is collected in the Emergency Plan form included in the admission package.
- If the patient goes to any other place, the Agency must re-establish the services ASAP where the patient is: family home, shelter, etc.
- Every year the Agency must complete (usually in May, before hurricane season begins on June 1st, our most common disaster type): Disaster Drill, Table Top Exercise, staff training, Hazard Communication selection, and all required Emergency Management documentation (included in the website, Safety Minute).
- Explain that the agency executives and all staff will monitor a battery radio (usually the only source of information during a hurricane, because there is no electricity or internet). After an emergency, if it is not possible to contact the patient or family (because phone services are not working), staff will go where we have registered the patient will be: patient's house, family house, shelter, etc.

- The Agency will maintain a Staff Meeting Place (Agency office), explained to all staff during emergency training and drills. Staff are oriented to have a battery radio to monitor community emergency agencies, authorities' bulletins and news; if communication fails, they are oriented to be at our office building at 9 am the day after authorities communicate that streets are safe, to reinstate our services ASAP. If the office is not in working condition, we will meet in the parking lot.
- If our office is totally destroyed, we will temporarily transfer the patients to another Agency with which we have a signed backup contract, until we can operate again.

** At the end of the CEMP Manual there are all Special Needs Registry forms for your counties.*

Staff Records Privacy

All staff files will be in a locked cabinet, accessed only by authorized staff. All in-services for staff are good for 2 years (24 hrs for professional staff: RNs, LPNs, Therapists; aides need 12 hours annually after the initial 75 hours). Office orientation in the office will use cards, manuals, board, etc. Training at https://homecareoffice.com/StaffTraining.htm.

ALL FIELD STAFF MUST BE REGISTERED IN THE AHCA CLEARINGHOUSE (Roster). IDs required. Criminal background and medical results **MUST BE IN A CONFIDENTIAL ENVELOPE**. PHYSICAL EXAM complete (initial TB test required for field staff: RNs, LPNs, aides).

Verifications

License	https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders
eVerify	https://www.e-verify.gov
Sex offender	https://www.nsopw.gov/
OIG	https://homecareoffice.com/hr_duties.htm
Alzheimer's (ADRD)	1 hr initial training within 30 days of hire, then 2 hrs within 7 months (https://elderaffairs.org/adrd-training/#training)

Mandatory Training

Alzheimer's, HIV, CPR up to date (not on-line), Physical Exam. Must have a copy of the rest of the trainings.

How do you evaluate an employee before and after hiring?

On the application date a practical and written test is completed (test results on the last page of the HR manual), verified and evaluated by the RN in charge (the competency test must be completed and signed by another RN). After 90 days the Probation Period evaluation is completed, and then an annual practical competency in the presence of the employee serving a patient.

Aide Services

How do you assign the Aide duties?

After the first nursing visit assessment (SOC), the RN generates the Aide Care Plan and educates and trains the aide in their responsibilities in the care/service of the client, and supervises every 14 or 60 days to verify that the plan is followed. All duties will be detailed; no PRN or as-needed tasks will be used.

Can the Aide assist with patient self-administered medications?

Yes, if ordered, and the aide has completed the 2-hour training and has been educated in the duty by the Admission RN as part of the Aide Care Plan assignment, and the patient is informed/approves. A signed patient consent will be in

the patient record (CONSENT, Agency Forms manual, last page).

How do you know if the CNA/HHA is doing what she is supposed to do?

The aide will be supervised every 14 or 60 days (depending on the program and service provided) to verify that the Plan of Care is followed, infection prevention is followed, etc. Also, every 60 days (regular home health episodes): Evaluation of Services, Surveys and the 60 Days Summary Report will be completed. HHA progress notes will also be reviewed to verify they are following the Aide Care Plan.

How do you inform your staff about your policies and procedures?

On the application date, as part of the initial orientation, they are informed about their rights and the availability of the Policy Manual for review, discussion and participation in any needed revisions or updates. A Staff Handbook will also be provided to each applicant.

Key Staff

Resumes for key staff must be up to date and explain supervisory experience: Administrator, DON, Alternate.

ACCREDITATION PHONE NUMBERS, AHCA and Federally Funded Agencies information (on the cover of the sign up package).

HIPAA (Privacy)

- The Agency will comply with all HIPAA guidelines and regulations. HIPAA exemptions: **Treatment** (if the patient goes to the hospital, the patient's condition, services provided, etc. can be shared with the hospital), **Billing** (any Program Management Authority like Humana, United Healthcare, etc. has the right to request copies of members' records to verify program guidelines are in compliance), **Regulation** (if AHCA, the healthcare regulatory agency in Florida, visits the agency, they have the right to review records to verify Florida Statutes and Standards are in compliance).
- Explain that all patients' records will be stored in a locked cabinet; only authorized staff will access patients' records; no patient information will be shared with third parties (like lawyers, family members) unless authorized in writing by the patient.
- The Agency will maintain a Visitors Log at the office entrance, which must be signed, to control who visited the office in case a HIPAA breach is detected, to facilitate investigation and solution.
- Staff in the Medical Records department will maintain a Chart Movement Log, to be sure any record requested by staff is returned when the work is finished and that no record is left on a desk outside the locked cabinet.

IV Therapy

The Agency can provide IV therapy services, **yes**, if ordered, a fully documented procedure is received from the patient's physician, and we have qualified staff. An LPN can't complete the 1st/last visit and must have 30 hours of IV training to follow up IV therapy services.

General

COMPLAINTS: A Complaint Log will be maintained (form at https://homecareoffice.com/Logs.htm).

Steps: 1) Receive the complaint 2) Solution 3) Plan to prevent the problem from repeating (always staff training) 4) Follow up on solution satisfaction. Clinical calls and patient-related services must be solved ASAP.

A more complex complaint (like a DC dispute, etc.) should be in writing/phone (LOG completed). Immediately the DON or Administrator shall conduct an investigation to determine its validity, and the Administrator/DON will issue a written decision on the grievance ASAP, but no later than thirty (30) days after its filing. The grievant may appeal the decision within 15 days (30 days to respond). No consequences for any complaints.

Close Agency voluntarily

First step: transfer all patients to another Agency, then complete the AHCA application, return the license, close contracts, providers, etc.

INFORMATION needed on the Agency main entrance door: Agency name, 24 hrs phone, and hours of operation posted. All licenses (AHCA, City, Business) and the Organizational Chart must be framed at the front desk.

Abuse Investigation

During staff initial orientation they are trained that any allegation or expected abuse by anyone, or suspicion of mistreatment, neglect or abuse, should be immediately reported to the employee's supervisor or DON. Employees who suspect or witness an abusive act by a patient's caretaker should notify their supervisor or the Administrator/DON immediately. The Administrator is responsible for coordinating the investigation within 3 days and completing the report and a plan to prevent it from happening again within 30 days (plan: always staff training).

How do you track if a patient falls or there is an incident? How do you know whether the patient's health is declining or it is the staff's fault? When should staff report a change in the patient's health?

As part of staff initial orientation (on the application date), staff are oriented that ANY significant finding, like a decline in the patient's condition, weakness, or safety measures needed in the patient's home (clean pathways, bed rails, etc.) as part of the Aide Care Plan, must be reported to the Agency RN in charge to complete the incident report and take measures to help improve the patient's condition and safety. We will maintain a log of any incident, and the program and the patient's physician will be notified. If the patient's health is affected (like a fall or hospitalization), the care plan will be updated in collaboration with the physician or enrolled health care program. Supervisor reports will be reviewed to verify the assigned aide follows the service plan, infection prevention and safety measures.

Alzheimer's, Offices & Admissions

Do you treat Alzheimer's patients? If so, what is the protocol?

All field staff will complete the 1 hour within 30 days of hire and the 2 hrs ADRD training within 7 months; we will maintain records of the training. New employees have up to 9 months to complete the required training. Any significant finding will be reported to the agency immediately. Training at https://elderaffairs.org/adrd-training/#training.

Do you have other agencies, like remote offices or places where people drop off notes (satellite office)?

NO

If the RN or Administrator worked in other agencies:

They will always be available in case of an emergency or Agency need, and will use any means of communication: emails, texts, phone calls. Always available: **YES**

How do you know the patient received all the proper documents and admission package?

It will be completed by our DON or another qualified admission RN; a supervisor will verify that all admission documentation was completed, discussed with the client/family, and left in the patient's home folder.

QAPI (Quality Assurance Performance Improvement)

All policies are included in the Policy Manual (Evaluation of Agency Program, Section D) and the QAPI Manual.

WHEN	QAPI ACTIVITY
1st Day	QAPI starts on admission, Sign Up day. Your QAPI staff must review all S/U papers, documentation, OASIS or comprehensive assessment to verify that the MD order is reflected in the admission documentation, including medications, orders and evaluations.

WHEN	QAPI ACTIVITY
Every 2 weeks	At least every 2 weeks: review the quality of progress note documentation for all disciplines (reflecting the Plan of Care and frequency of visits compliance).
Every 30 days	A Case Conference Report must be completed with the participation of all disciplines involved in the patient care and the Agency DON or qualified RN, proving coordination of care and assuring our services cover all patient care needs. Field staff complete a progress report (reflecting any progress/deterioration); any adjustment or modification to the plan of care must be authorized by the patient's physician.
Every 60 days	Regular home health episode: service and patient records reviewed and audited, verifying care plan compliance and frequency; Evaluation of Services, Patient Surveys and the 60 Days Summary Report reflecting the patient condition. If goals are met the patient is evaluated for discharge, or recertification if continuing service is documented and approved by the patient's physician (full documentation must be completed).
Quarterly	After we start providing services, a quarterly QAPI / Chart Review meeting is held with all disciplines providing services in the quarter, and a full report about our services is provided to the Board of Directors.

State Licensure Interview Questionnaire: Administrator

Sample questions, with the answers for an initial survey (shown in teal).

QUESTION	ANSWER
How long have you been the administrator?	**APPLICATION DATE**
Do you manage other HHA's? If so, where are they?	**NO**
See H-0217 if the HHA is located in a retirement community.	**NO**
How many patients do you serve? Weekly or monthly.	**N/A, or current number of active patients**
What services do you offer? What services are contracted?	**SN (DIRECT); HHA (CONTRACT)**
How many direct employees do you have? (List # by type, i.e. R.N.)	**2 RN, OFFICE STAFF IF APPLICABLE**
What geographic area do you service? (List the counties)	**DADE**
What are your normal business hours?	**9-5**
How do you handle 24-hour coverage (for skilled)?	**CALL TRANSFER TO ON-CALL PERSON**
Are there other locations?	**NO**
Satellite offices or drop off sites?	**NO**
Does the home health agency have space in an ALF in addition to the main office? If so, is it designated as a satellite office or drop office?	**NO**
Do you advertise that you provide services to patients with Alzheimer's Disease? If so, what information do you have about your services that distinguishes the care as being especially applicable to such persons?	**NO**
Do you provide home health aide training or use the AHCA competency test? If training, who is the primary trainer?	**DON**

QUESTION	ANSWER
How are patients notified of the Abuse Hotline toll-free number?	LABELS ALL OVER S/U, FOLDER, HANDBOOK, INITIAL VISIT
What is being done by staff to collect information to assist special needs patients in getting registered with the local emergency management agency? Did you or someone on your staff contact the local emergency management agency to find out what information needs to be submitted?	YES, WE ARE READY WITH ALL FORMS
How is the prioritized list of patients who need continued services compiled & maintained?	YES, WILL BE
If you are in one of the specified counties, was the Emergency Management Plan reviewed by the county health department?	YES, EMAIL
If there was an emergency situation in the counties covered by the HHA, how were patients contacted? Was the plan implemented?	BY ANY WAY OF COMMUNICATION, OR DRIVING TO THE PATIENT'S PLACE OF RESIDENCE. PLAN IMPLEMENTED

Home Health Agency Licensure Survey: Director of Nurses Interview

The following standards should be checked on the initial survey and when there is a new Director of Nursing (DON). Therapy-only HHAs are not required to have a DON, so the relevant questions can be asked of the administrator or the person who oversees the therapists. The asterisked items (*) should be checked on subsequent surveys, at the discretion of the surveyor and as time permits.

STANDARD	REVIEW & DISCUSSION ITEMS
H-0220 Director of Nursing (check if new DON)	Check qualifications if not done on a previous survey. **RESUME** How many HHAs does the DON work for? Is she or he the DON in all HHAs? **ONLY ONE** If the HHA is part of a retirement community, does the DON serve as DON for other facilities on campus? **NO**
H-0222 Alternate DON	Check qualifications if not done on a previous survey or if changed. **RESUME**
H-0223 DON duties	Review procedures for safety, universal precautions and infection control if not done on a previous survey. How are staff informed of the procedures? **ORIENTATION** Does the DON perform duties as listed in this standard? **YES**
H-0224 DON quality assurance program *	Review procedures if not done on a previous survey. **QA STEPS** Discuss whether QA procedures have changed. As time permits, review minutes or other documentation from the DON on QA.
H-0231 RN assign LPN & HH aides *	How does the RN assign portions of patient care to the LPN & home health aide? **PLAN OF CARE ASSIGNMENT, ORIENTATION**
H-0235 Supervision of LPN *	How does the RN supervise the LPN? **Q30D**
H-0240 Home Health Aide & CNA supervision *	How does the RN supervise the Home Health Aide & C.N.A? **SKILLED CASES Q14D, NON-SKILLED Q60D**

STANDARD	REVIEW & DISCUSSION ITEMS
H-0250, 251, 252, 254 HH Aide & CNA assist w/ meds: discuss procedure, assessment & training *	What training and oversight is provided to Home Health Aides & C.N.As that provide assistance with medication? Who informs the patient that an unlicensed person will assist? **THE ADMISSION RN, IF THE HHA HAS THAT TRAINING** Who assesses the patient to determine if stable enough and OK for the aide to assist? **THE ADM. RN**
H-245 HH Aide Competency Test	If the test is used by the HHA, who administers & grades the written test? Who administers & rates the practical portion? **THE DON**
H-390 Lab Test (check on initial visit or if not checked before)	Does the HH agency do any lab tests? **WAIVER ONLY** If so, does it have a license and/or CLIA waiver from AHCA's Lab Unit? **YES, APPLIED (SEE COPY)**
H-0305 Responsibility over contractors *	How does the HHA monitor and manage care provided by contract agencies? **N/A, BUT WE ARE RESPONSIBLE FOR ANY CONTRACT, AND MONITORING/SV Q2WKS**
Other	

Guidelines: The State Licensure Survey for Initial Licensure of Home Health Agencies

Pre-Survey Activity

In preparation for the survey, review documents including licensure applications and the resume of the administrator or director of nursing. Review survey instructions, minimum standards and guidelines as needed.

Entrance Conference

The home health agency is in compliance with state law and rules governing home health agency licensure. During the interview find out how many staff have been hired or contracted and get a list. Arrange for an interview with the DON if required, indicating an approximate time to ensure availability. See the Licensure Home Health Interview Questionnaire for the Administrator for minimum questions that should be asked. Additional questions may be added at the discretion of the surveyor.

Ask the administrator to provide the items listed on the Entrance Conference Checklist within the specified time frames.

Interview with Administrator

Interview the Administrator or DON using the review and discussion items on the Home Health Agency Licensure Survey Director of Nursing Interview or another similar list or worksheet. For therapy-only HHAs, you could interview the staff person who oversees the work of the aides, or the administrator.

Record Review

Personnel: Record review activity is required for personnel files and patient records. Select for review the files of all employees and contractors hired to date. Use the worksheets provided (Personnel Record Review and Certified Nursing Assistant/Home Health Aide Training Review Form) or other similar worksheets to determine compliance with the standards. Use surveyor judgement to determine if other files need to be reviewed.

Interview with Administrator

Policies & Procedures: Determine if the agency is set up to accept patients, with policies & procedures for assessment, monitoring and evaluation, and sufficient personnel hired to offer the services listed in the application, or such hiring planned. **ALREADY APPROVED, will not be reviewed.**

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Emergency Management Plan

Proof of Submission only. ALREADY APPROVED, will not be reviewed.

Ask the administrator to see the HHA's emergency management plan. Use the Worksheet for Review of HHA Emergency Management Plans to check for essential required items in the plan. Ask for evidence that the plan has been submitted for review to the Health Department.

Minimum Standards to check on surveys

The minimum standards (tags) to be checked on the survey are incorporated into the worksheets and are shown in the chart below. The method of review is indicated in the Rev column, with the key for the letters used at the bottom of the chart. Additional tags may be added at the discretion of the surveyor, as time permits.