

## HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

1. Name of Facility:		11. Provider No.: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
2. Street Address:		12. Type of Survey: <input type="checkbox"/> Initial (G2) <input type="checkbox"/> Resurvey (G3) 1 = Standard      4 = 1 and 2 2 = Partial Extended      5 = 1 and 3 3 = Extended      6 = 1, 2 and 3	
3. City and/or County:	4. State:	13. Eligibility: (G7) <input type="checkbox"/> 1 = Medicare <input type="checkbox"/> 2 = Medicaid <input type="checkbox"/> 3 = Both	
5. Zip Code:	6. Telephone No. (G4)		
7. State/County Code: (G5)	8. State/Region Code: (G6)	14. Has there been a change of ownership since last survey? (G9) <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Name of Administrator:			
10. Discipline of Administrator: (G8) <input type="checkbox"/> 1 = RN/LPN      5 = Medical/License Social Worker      9 = Other <input type="checkbox"/> 2 = Physician      6 = Pub Adm/MBA/ACCT <input type="checkbox"/> 3 = PT/OT      7 = Lawyer <input type="checkbox"/> 4 = Speech Path/Audiologist      8 = Proprietor		15. A. Is this home health agency also a Medicare certified hospice? (G10) <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, give the hospice Medicare provider number: (G11) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
15. B. Does this home health agency operate sub-units? (G12) <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, how many: (G13) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>			
15. C. Is this home health agency a sub-unit? (G14) <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, parent agency provider number: (G15) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>		15. D. Does this home health agency or sub-unit operate branch(es)? (G16) <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, how many: (G17) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>  If yes, give official name and mailing address of each branch (include street, state and zip code):	
15. D. Does this home health agency or sub-unit operate branch(es)? (G16) <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, how many: (G17) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>  If yes, give official name and mailing address of each branch (include street, state and zip code):			
<input type="checkbox"/> If more space is needed, check here, use a separate page and attach.			

16. Type of Agency: (G18)

<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	01 = VNA 02 = Combination Government Voluntary 03 = Official Health Agency 04 = Rehab based program* 05 = Hospital based program* 06 = Skilled Nursing Facility/Nursing Facility based program* 07 = Other
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\*If Medicare/Medicaid certified give the provider number: (G19)

     

17. Type of Control: (G20)

<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<p><b>Voluntary Non-Profit</b> 01 = Religious Affiliation 02 = Private 03 = Other</p> <p><b>For Profit</b> 04 = Proprietary</p> <p><b>Government</b> 05 = State/County 06 = Combination Govt. and Voluntary 07 = Local Government</p>
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*(continued)*

18. Services Offered: (G21)  
 1 = Provided by Agency Staff  
 2 = Under Arrangement  
 3 = Combination

<input type="checkbox"/>	01 = Nursing Care
<input type="checkbox"/>	02 = Physical Therapy
<input type="checkbox"/>	03 = Occupational Therapy
<input type="checkbox"/>	04 = Speech Therapy
<input type="checkbox"/>	05 = Medical Social Worker
<input type="checkbox"/>	06 = Home Health Aide
<input type="checkbox"/>	07 = Intern/Resident
<input type="checkbox"/>	08 = Nutritional Guidance
<input type="checkbox"/>	09 = Pharmaceutical Services
<input type="checkbox"/>	10 = Appliance and Equipment Service
<input type="checkbox"/>	11 = Vocational Guidance
<input type="checkbox"/>	12 = Laboratory Services
<input type="checkbox"/>	13 = Other

19. Staffing (List full-time equivalent):

Registered Nurse (G22)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Licensed Practical Nurse (G23)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapist (G24)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapist (G25)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Speech Pathologist/Audiologist (G26)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Social Worker (G27)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Home Health Aide (G28)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacist (G29)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Dietitian (G30)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
All Others (G31)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>

20. Home Health Agency provides directly: (G32)

<input type="checkbox"/>	1 = Home Health aide training program
<input type="checkbox"/>	2 = Home Health aide competency evaluation program
<input type="checkbox"/>	3 = Both
<input type="checkbox"/>	4 = Neither

21. Number records reviewed with home visits (G33)

Number records reviewed, no home visits (G34)

Number of home visits with no records review (G35)

Total records reviewed (G36)

Total home visits (G37)

22. Patient census since last standard survey:

**Admissions:**  
 (G38) \_\_\_\_\_ Unduplicated admissions  
 (G39) \_\_\_\_\_ Readmissions

**Discharges**  
 (G40) \_\_\_\_\_ Hospital discharges  
 (G41) \_\_\_\_\_ Nursing home discharges  
 (G42) \_\_\_\_\_ Goals met discharges  
 (G43) \_\_\_\_\_ Death discharges  
 (G44) \_\_\_\_\_ Total discharges

23. Surveyor summary: Based on the reviews of the patients from this home health agency including all information surveyed in the standard survey and using the Functional Assessment Instrument (FAI), this home health agency: (G45)

1. Provides care that promotes a high potential for reaching the highest attainable levels of functioning for its patients. There is no evidence of need for a partial extended or extended survey.

2. Provides care that promotes a moderate potential for reaching the highest level of functioning for some but not all of its patients. There are standard level deficiencies and need for a partial extended survey. If no conditions are out of compliance, a Plan of Correction will be requested for the standard level deficiencies.

3. Provides substandard care. There are condition level deficiencies in one or more Conditions of Participation. There is an immediate need for an extended survey.

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1. NAME OF FACILITY:

4. DATE:

2. DEFICIENCIES

3. Standard \_\_\_\_\_ Extended \_\_\_\_\_ Partial Extended \_\_\_\_\_

Data Tag No.

COP/Stnd No.

COMMENTS

2. DEFICIENCIES		3. Standard _____ Extended _____ Partial Extended _____
Data Tag No.	COP/Std No.	COMMENTS

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Record deficiencies identified on a Standard Survey, Partial Extended Survey, and/or Extended Survey on different pages, check the type of survey under item 3 and enter the date of the survey in item 4.

- A. In the first column, identify the data tag number.
- B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter "CoP" below the regulatory citation.
- C. In column three, describe the findings and evidence under "Comments."
- D. Draw horizontal lines to separate identified tag numbers.
- E. If more space is needed, photocopy the "Deficiencies & Comments" page and continue the recording (front and back).
- F. Each surveyor must sign the certifying statement on the last page for each type survey(s) conducted (i.e., Standard Survey, Partial Extended Survey, and/or Extended Survey). If more space is needed to list deficiencies identified during a Partial Extended Survey, photocopy page.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0355. The time required to complete this information collection is estimated to average 1 hour 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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## A. STANDARD SURVEY

I certify that I have reviewed each HHA Condition of Participation and related Standard(s) included in the Standard survey and except as indicated on this form, the facility was found to be in compliance with the standards and/or the Conditions of Participation.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

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## B. PARTIAL EXTENDED SURVEY

I certify that I have reviewed each HHA Condition of Participation and related Standard(s) listed below, and except as indicated on this form, the facility was found to be in compliance with the standards and/or the Conditions of Participation.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

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## C. EXTENDED SURVEY

I certify that I have reviewed all of the HHA Conditions of Participation and related Standard(s) not reviewed during the Standard Survey and/or Partial Extended Survey and except as indicated on this form, the facility was found in compliance with the standards and/or Conditions of Participation.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_