FORM APPROVED
OMB N0. 0938-0355

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

1. Name of Facility:

11. Provider No.: ☐☐☐☐☐☐

2. Street Address:

12. Type of Survey:
☐ Initial (G2) ☐ Resurvey (G3)
1 = Standard
2 = Partial Extended
3 = Extended
4 = 1 and 2
5 = 1 and 3
6 = 1, 2 and 3

3. City and/or County:

4. State:

5. Zip Code:

6. Telephone No. (G4)

7. State/County Code: (G5)

8. State/Region Code: (G6)

13. Eligibility: (G7)
☐ 1 = Medicare
2 = Medicaid
3 = Both

9. Name of Administrator:

10. Discipline of Administrator: (G8)
☐
1 = RN/LPN
2 = Physician
3 = PT/OT
4 = Speech Path/Audiologist
5 = Medical/License Social Worker
6 = Pub Adm/MBA/ACCT
7 = Lawyer
8 = Proprietor
9 = Other

14. Has there been a change of ownership since last survey? (G9)
☐ Yes ☐ No

15. A. Is this home health agency also a Medicare certified hospice? (G10)
☐ Yes ☐ No

If yes, give the hospice Medicare provider number: (G11) ☐☐☐☐☐☐

B. Does this home health agency operate sub-units? (G12)
☐ Yes ☐ No

If yes, how many: (G13) ☐☐

C. Is this home health agency a sub-unit? (G14)
☐ Yes ☐ No

If yes, parent agency provider number: (G15) ☐☐☐☐☐☐

D. Does this home health agency or sub-unit operate branch(es)? (G16)
☐ Yes ☐ No

If yes, how many: (G17) ☐☐

If yes, give official name and mailing address of each branch (include street, state and zip code):

☐ If more space is needed, check here, use a separate page and attach.

16. Type of Agency: (G18)
☐☐
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

*If Medicare/Medicaid certified give the provider number: (G19)
☐☐☐☐☐☐

17. Type of Control: (G20)
☐☐
Voluntary Non-Profit
01 = Religious Affiliation
02 = Private
03 = Other
For Profit
04 = Proprietary
Government
05 = State/County
06 = Combination Govt. and Voluntary
07 = Local Government

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(continued)

18. Services Offered: (G21)

1 = Provided by Agency Staff
2 = Under Arrangement
3 = Combination

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

19. Staffing (List full-time equivalent):

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

20. Home Health Agency provides directly: (G32)

- ☐ 1 = Home Health aide training program
- ☐ 2 = Home Health aide competency evaluation program
- ☐ 3 = Both
- ☐ 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/Stnd No.	COMMENTS

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

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.

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

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: _____

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: _____

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: _____