Spring Conference
Wednesday, May 10, 2023
2:30pm-3:45pm

5A. Plan of Care Deficiencies and Documentation Tips

Presented by:
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Plan of Care Deficiencies and Documentation Tips

Learning Objectives

• Participants will be able to identify 3 regulatory bodies that impact surveyor and auditing activities
• Participants will be able to interpret the conditions of participation relating to the plan of care
• Participants will also correctly identify and correct plan of care common mistakes that can lead to deficiencies
• Participants will learn how to remedy plan of care deficiencies related to patient safety
Survey Deficiencies

• Home Health surveys are completed by state surveyors (Texas HHSC) or deemed accrediting organization surveyors (Joint Commission, CHAP, ACHC)
• Top deficiency reports can vary
• One commonality among all top deficiency reports: Plan of Care (POC)
  • Plan of care lacks all required items
  • Plan of care not followed
  • Lacking a medication reconciliation
  • Visit schedule/frequency not followed
  • Lacks measurable outcomes and goals

Importance of the POC

• Foundation for patient care
• **REQUIRED** - Condition of participation, home health licensing regulation, condition of payment, accrediting organization standard
• Outlines why the patient is on service and everything that your agency will do for the patient to meet care goals
• Goals for care
• Details discipline frequencies
• Staff directives (safety measures, patient education, planned treatments, etc.)
• Contains the most physician/provider orders
Regulations and Guidance

- Texas Administrative Code Title 26, Chapter 558: Licensing Standards for Home and Community Support Services Agencies
- Code of Federal Regulations Title 42, Chapter 4, Part 484: Home Health Services
  - [https://qsep.cms.gov/data/2505/SOM_APPENDIX_B_FOR_HHA.pdf](https://qsep.cms.gov/data/2505/SOM_APPENDIX_B_FOR_HHA.pdf)
- Accrediting organization standards (Joint Commission, CHAP, ACHC)

Deficiencies and Compliance

- Compliance with the CoPs assures that Medicare/Medicaid beneficiaries receive a basic standard of care and that safety requirements are met
- It also reduces agencies’ legal risk from patients and CMS
- Deficiencies at surveys can result in corrective action plans, monetary sanctions, and increased reporting requirements
- Can also result in exclusion from the Medicare program
Medicare Conditions of Participation related to the Plan of Care

G570 Care Planning, Coordination of Services, and Quality of Care

§484.60 Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions.

Each patient must receive an individualized written plan of care, including revisions or additions.

Common areas for deficiencies:
- Patient has not received a written plan of care
- Patient has not been notified of POC revisions/additions
G572 Plan of Care

§484.60 (a)(1) Each patient must receive...individualized plan of care...which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration.

The plan of care must be signed by the certifying physician or allowed provider type.

Common areas for deficiencies:
- A different physician or provider signs the initial POC than who is listed as certifying provider
- POC is not individualized – avoid generalized interventions

EXAMPLE of generalized interventions

SN to provide skilled assessment and teaching on all diagnoses.
SN to provide instruction and teaching on infection control.
SN to provide safety instruction with regards to identified risks.

What is wrong with these statements?
- Not individualized

Better!
SN to provide skilled assessment and teaching on CHF, COPD, atrial fibrillation. SN to provide instruction and teaching on UTI, prevention measures, signs/symptoms, and when to notify the nurse or physician. Pt identified to be at risk for pressure sores. SN to provide skilled assessment to identify and mitigate risk factors and provide instruction and teaching on pressure sore development.
G574 Plan of Care Requirements

§484.60(a)(2) The individualized plan of care must include the following:

(i) All pertinent diagnoses;
(ii) The patient’s mental, psychosocial, and cognitive status;
(iii) The types of services, supplies, and equipment required;
(iv) The frequency and duration of visits to be made;
(v) Prognosis;
(vi) Rehabilitation potential;
(vii) Functional limitations;
(viii) Activities permitted;
(ix) Nutritional requirements;
(x) All medications and treatments;
(xi) Safety measures to protect against injury;
(xii) A description of the patient’s risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors;
(xiii) Patient and caregiver education and training to facilitate timely discharge;
(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;
(xv) Information related to any advanced directives; and
(xvi) Any additional items the HHA or physician may choose to include

Common areas for deficiencies:

- Diagnoses listed on the clinical notes (hospital dc summary, F2F encounter) but not on POC
- Chronic conditions that are still being monitored (diabetes, asthma, CHF, etc.)
- Narrative notes listing diagnoses that are not supported in the POC or clinical documentation
- Not having clinical documentation to support the diagnosis listed on the POC

List all known diagnoses in the POC (and have supporting clinical documentation)
G574 Plan of Care Requirements
§484.60(a)(2) The individualized plan of care must include the following: 

**Nutritional requirements**

The patient’s diet must be on the plan of care. This includes enteral and parental nutrition as well as fluid restrictions.

**Common areas for deficiencies:**
- Inconsistent diet descriptions in narrative notes (Heart healthy, low sodium, low fat)
- Lacks nutritional requirements for enteral or parental feedings
- Lacks fluid restrictions for dialysis patients

G574 Plan of Care Requirements
§484.60(a)(2) The individualized plan of care must include the following: 

**The frequency and duration of visits to be made**

Visits must have a frequency order that includes the duration of time (Examples: SN 2w1, then 1w8, PT 2w3)

**Common areas for deficiencies:**
- Discipline frequency not listed for all disciplines (or inaccurate)
- Discipline frequency not listed for continuing discipline into next certification period (not transferred from order or therapy evaluation)
- Frequency listed but lacking duration
- Non-specific PRN visit orders
EXAMPLE

PRN SN visit x 2

What is wrong?
• There is no description of the signs and symptoms that would warrant a visit.

Better!
PRN SN visit x 2 during certification period for patient c/o UTI symptoms of burning, frequency, odor, confusion, and/or increased temperature.

EXAMPLE

PT eval week of 6/1/2023
MSW eval x1

What is wrong?
• There is no description of services to be provided (unless you have them listed somewhere else in POC)

Better!
PT eval x 1 wk of 6/1/2023 for evaluation for strengthening and gait training
MSW eval x 1 wk of 6/1/2023 for assessment for provider services
G574 Plan of Care Requirements
§484.60(a)(2) The individualized plan of care must include the following: **All medications and treatments**

All patient medications and treatments, including over-the-counter medications, must be on the plan of care.

**Common areas for deficiencies:**
- Plan of care medication list lacks ordered oxygen
- Plan of care medication list lacks OTC meds (Tylenol, Ibuprofen, hydrocortisone cream)
- Narrative notes state medications that the patient is taking, but no order found
- Treatments include simple wound care and medications used

G574 Plan of Care Requirements
§484.60(a)(2) The individualized plan of care must include the following: **Safety measures to protect against injury**

Any safety precautions that are indicated for the patient during the planned episode of care

**Common areas for deficiencies:**
- Safety measures lacking for devices and ports that may not be the focus of care. POC still should address safety!
- Medication list includes anticoagulants/antiplatelets, but POC lacks bleeding precautions
- Safety measures not listed on the aide care plan
G574 Plan of Care Requirements

§484.60(a)(2) The individualized plan of care must include the following: A description of the patient’s risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.

These risks are assessed during the comprehensive assessment (OASIS M1033)

**Common areas for deficiencies:**
- Risks are not identified on admission
- Risks are identified on OASIS, but are not on the plan of care

**EXAMPLE statement for a risk intervention**

*Risk Identified: More than 5 medications*

SN to minimize/eliminate risk for hospitalization d/t polypharmacy with instruction to patient education on high-risk medications, indications, side effects and adverse reactions, how to take, and when to notify the physician.
G574 Plan of Care Requirements
§484.60(a)(2) The individualized plan of care must include the following: Patient-specific interventions and education; measurable outcomes and goals identified by the agency and the patient

Must have interventions to address the primary diagnosis and focus of care. The goals must be specific to the patient and measurable.

Common areas for deficiencies:
• Plan of care lacks the patient identified goal (“Patient states he would like to be able to ambulate to mailbox by himself”)
• Goals are not measurable
• Goals lack a timeframe (i.e., Patient will be...by EOE or Patient will be...by 3/4/2023.)

Example

Pt will understand CHF diagnosis by end of certification period.
Pt will know the signs and symptoms of a respiratory infection.

What is wrong with these goals?
• Not specific
• Not measurable
• No goal date

Better!
Patient will be able to identify 2 complications of CHF by 6/15/2023; Patient will be able to name 3 signs and symptoms of a respiratory infection by 6/30/2023.
G576 Plan of Care Orders

§484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care.

Any orders received during the 60-day certification period should be reflected on the next recertification POC (if applicable and current)

Common areas for deficiencies:
- Verbal order for plan of care not documented
  - Tip: Place verbal order statement on POC (“Contacted Dr. Smith on 7/1/2023 at 1400, MD is in agreement with plan of care”)
- Order received during certification period (and continues to next) but it is not on new recertification POC

G592 Revisions to the Plan of Care

§484.60(c)(2) A revised plan of care must reflect current information from the patient’s updated comprehensive assessment, and contain information concerning the patient’s progress toward the measurable outcomes and goals…

The revised plan of care (i.e., recertifications) must show the patient’s progress toward meeting the goals that have been established

Common areas for deficiencies:
- The recertification POC lacks a description of how the patient has or has not met established goals
  - Tip: The recert POC should have a descriptive narrative that gives an overview of what has been accomplished with the planned care, what was not accomplished and reasons for not meeting goal, and supportive statements for continued care (medical necessity).
- Goals and outcomes are not measurable
- Outdated orders on the POC
Example statement that reflects need for recertification

Patient recertified for continuance of plan of care with updated physician changes noted in plan of care. Pt has identified knowledge deficits regarding medication regimen and 2 new medications that were added at physician appointment 5/1/2023 due to continued lower extremity edema and complaints of shortness of breath. Patient has met goals related to oxygen therapy and safety, is able to recall 50% of disease teaching, but has not met goals for medication knowledge and disease management. Pt requires continued skilled assessment and disease process teaching.

✓ Measurable goals
✓ Why they have not been met
✓ Progress

G594 Communication of Revisions to POC

§484.60(c)(3)(ii) Any revision to the plan of care due to a change in health status must be communicated to the patient, representative, caregiver, and all physicians issuing orders for the HHA plan of care.

Changes must be communicated to those involved in the care of the patient.

Common areas for deficiencies:
- Wound clinic orders not communicated to the certifying physician.
  - Tip: Put statement on POC re: consulting physicians ("SN may take orders from consulting physicians/providers") *must still communicate new orders, but will not need signature of certifying provider
- New orders not communicated to the patient (frequency changes, medication changes, wound care orders, etc.)
  - Tip: Note on the actual order who was notified of changes (i.e., Patient and all care providers notified of changes 1/2/2023, 1500)
Notable Deficiencies related to Documentation Errors

**G442**

§484.50(c)(8) Receive proper written notice, in advance of a specific service being furnished or in advance of the HHA reducing or terminating on-going care

Notable Deficiencies related to Documentation Errors

**G536**

§484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions (ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance)
Notable Deficiencies related to Documentation Errors

G614

§484.60(e)(1) Written Information to the patient: Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA

G710

§484.75(b)(3) Responsibilities of skilled professions. Skilled professionals are responsible for providing services that are ordered by the physician as indicated in the plan of care
Notable Deficiencies related to Documentation Errors

G800

§484.80(g)(2) The duties of the home health aide include the provision of hands-on personal care, the performance of simple procedures, assistance in ambulation or exercises, and assistance in administering medications.

Additional POC Items
Medications

- Medications include prescribed and over-the-counter
- Clinicians should ask the patient to show them their medication bottles
- Ask if there are any medications that are prescribed but not taking (and reason why!)
- Oxygen is considered a medication
- Medication listings should have name of the medication, dose, frequency/time, and route
- Avoid use of abbreviations (write out “units” instead of U)
- PRN medications must have qualifier (why the medication is needed)
  - Tylenol 650mg PO q4 hrs PRN for pain
- Topical medications must have site of application

Certification Statement

- A physician or allowed practitioner must certify (attest) that:
  - Home Health services are needed because the patient is confined to the home
  - The patient needs intermittent skilled nursing services, physical therapy, or speech therapy
  - A plan of care has been established
  - The patient is under the care of a physician or allowed practitioner
  - A face-to-face encounter occurred within the timeframes and was related to the primary reason for HH and was completed by a physician or allowed practitioner. The certifying physician or allowed practitioner MUST ALSO DOCUMENT THE DATE OF THE ENCOUNTER.

- Certification statements may be on the POC or on other documents
- Should be completed when care is established, but must be completed prior to billing
- Tip: Have certification statement WITH DATE of F2F encounter documented on POC
Medical Necessity and Focus of Care

- Medical necessity means that the services provided are reasonable and necessary
- Long LOS: Be sure that the record shows evidence of needed skill
- ADRs and medical necessity – Paint the picture
- Document exacerbations of Dx, new/changed Rx, hospitalizations, acute changes in condition, changes in caregiver status, complicating factors

Processes that Expose Deficiencies

- Medicare certification and licensure surveys
- RCD (Review Choice Demonstration)
- ADR (Additional Document Request)
- UPIC (Unified Program Integrity Contractors)
- TPE (Targeted Probe and Educate)
- CERT (Comprehensive Error Rate Testing)

Consequences of noncompliance: Education requirements, suspension of payments, reimbursement recoupments, prepay review, loss of accreditation status, disruption of services
Common Causes of Deficiencies

- **Omission of data** – clinical records lacking orders, signatures, lack of intervention documentation, lack of completed documents (F2F, consents, NOMNC, etc.)
- **Patient load increase** – less time for documentation, unfamiliar with new patients
- **Less experienced clinicians** – unfamiliar with documentation requirements
- **Incomplete documentation** (“it was done, it just wasn’t documented”)
- **EMR issues** – some EMRs lack all required sections of plan of care; need for supplemental narratives for compliance

Plan of Care and Deficiencies- Big Picture

- Foundation for care
- Clinicians should be looking at POC prior to every visit
- An easy-to-read POC is vital
  - Avoid all caps (difficult to read for anything beyond a phrase)
  - Utilize spacing
  - Make POC flow in a predictable format
  - Avoid having too many interventions and goals – Focus on the priorities
Any questions can also be emailed to Jennifer Amheiser, BSN, RN at jennifer@hc-link.com

1-888-258-1894
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QUESTIONS?

References and Resources


