

**NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
DIVISION OF HEALTH CARE STANDARDS AND SURBEILLANCE
BUREAU OF HOME HEALTH CARE SERVICES**

**Licensed Home Care Services Agencies
Article 36
Surveillance Process**

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Licensed Home Care Services Agencies Surveillance Process

A. Overview of Survey Process

5/12/98

1. Purpose

The purpose of the licensed home care services agency (LHCSA) surveillance process is to determine that the LHCSA personnel, equipment, rules, standards of care, quality improvement process and home care services are adequate and meet the requirements of Article 36 of the Public Health Law and applicable regulations.

For purposes of the LHCSA surveillance process, the scope of survey activities will include a review of the following health care services: nursing, home health aide, personal care aide, physical therapy, occupational therapy, speech/language pathology, nutrition, social work, respiratory therapy, physician and medical supplies, equipment and appliances.

2. Definition and Frequency of Surveys

Pre-opening survey – A full survey that is conducted prior to the issuance of a license. The full survey may lack the clinical record review if the agency is non-operational at the time of survey. The clinical record review will take place within six to nine months of the effective date of licensure. The area office program director will determine the need to conduct a pre-opening survey prior to the approval of a new license following the change of ownership of an existing agency.

Full Survey – A survey conducted at the discretion of the Department, but at least once every three years, which includes a review of all services provided by the agency and the systems in place to support those services.

The time interval between full surveys is determined as follows:

- Three years:
 - No deficiencies cited on the last full survey.
 - Accreditation visit conducted since last full survey without negative findings.
 - No substantiated complaints since the last full survey.
 - No more than three complaints since the last full survey.
 - No addition of services to the license since the last full survey.
 - Less than 50 percent increase in patient census since last full survey.
 - No change in administrative and/or responsible RN staff.
 - All required notifications, reports and questionnaires have been submitted to the department.

- Two Years
 - Less than five deficiencies cited as a result of the last full survey
 - No deficiencies cited on the last full survey that indicated negative patient outcomes.
 - No complaint investigations resulting in the citation of deficiencies since the last full survey.
 - All required notifications, reports and questionnaires have been submitted to the department in a timely manner.

- One Year
 - More than five deficiencies cited as a result of the last full survey.
 - Negative patient outcomes found on the last full survey.
 - Complaint investigation(s) resulting in the issuance of statement(s) of deficiencies.
 - More than three complaints received against an agency within a year.
 - Failure to notify the department as required of changes in the agency.
 - Failure to submit required reports and/or questionnaires in a timely manner.

Partial Survey – A survey that includes the review of one or more aspects of agency operation. A partial survey is conducted when there is:

- Need for a clinical record review as a post approval visit following a pre-opening survey which was conducted when the agency was non-operational;
- Need for a follow-up survey to verify agency compliance with a plan of correction from a previous survey or complaint investigation;
- A change in operator if a survey is indicated;
- A change in the delivery of services if a survey is indicated;
- Information coming to the attention of the Department such as complaints that lead the Department to believe the services may not be provided in accordance with the manner required by Section 3605 of the Public Health Law and the rules and regulations thereunder.

2. Summary of Steps in the Full Survey Process

A. Pre-Opening Surveys

The pre-opening survey process begins when the applicant notifies the Regional Office that the Agency is ready for survey and proceeds with the following steps:

- Step 1 - Regional Office staff mail out the pre-survey letter requesting materials and information to be submitted for review prior to scheduling the survey.
- Step 2- Surveyor reviews the submitted materials and information, the agency file and project application. These materials may be reviewed on site (see Step 5) if this is more expedient for the surveyor.
- Step 3 - Surveyor notifies applicant of any problem and requests corrective action.
- Step 4 - Upon determination that the pre-survey materials are in substantial compliance with the code, and on-site visit is scheduled with the application.
- Step 5 - On-site survey activities take place. Following completion of all activities, an exit conference is held with agency staff.
- Step 6 - Surveyor transmits the survey results to the applicant within 10 days of survey using Form DOH-1503, Statement of Deficiencies and Plan of Correction.
- Step 7 - If deficiencies are cited, the applicant returns the plan of correction to the Regional Office within 10 days.
- Step 8 Surveyor reviews the plan of correction and either accepts the plan or requests an amended plan. If the plan of correction is unacceptable, an amended plan is requested within 10 days and the provider has 10 days to respond. Failure of the agency to submit an acceptable plan of correction may result in a recommendation of enforcement or an abandonment of an application.
- Step 9 - For the initial survey, surveyor recommends issuance of a license based on Agency Compliance or an acceptable plan of correction. The Survey report, statement of deficiencies and plan of correction, if applicable, are sent to the Bureau of Home Care Services (BHHCS) within 10 days of receipt in the Regional Office.
- Step 10 - A post approval survey visit may be conducted on-site to verify correction Of Deficiencies. This review should be conducted no later than one year after the pre-opening survey. For an initial survey, any regulations unable to be adequately

judged during the initial survey process will be evaluated during the past approval visit.

B. Full Surveys

- Step 1 - The Pre-Survey Questionnaire is sent to the licensed agency by the Regional Office within the quarter that the survey is due to be conducted. (Appendix C). The completed questionnaire should be returned by the agency to the Regional Office within 30 days from receipt.
- Step 2 - Surveyor reviews the Pre-Survey Questionnaire, agency files and complaint investigations conducted since the previous survey.
- Step 3 - Surveyor notifies agency if pre-survey questionnaire does not contain required information. However, agency is not informed of date of scheduled survey.
- Step 4 - On-site survey activities take place, which include a clinical record review and possibly home visits. However, the agency is not informed of scheduled survey.
- Steps 5-7 - Same as Steps 6-8 for the Pre-Opening Survey process.
- Step 8 - First page of survey report, statement of deficiencies and plan of correction, if applicable, resent to the BHHCS within 10 days of receipt in the Regional Office

**Licensed Home Care Service Agencies
Surveillance Process**

B. FULL SURVEY ACTIVITIES

5/12/98

1. Correspondence to Providers

All correspondence regarding surveillance is sent to the Operator with a copy to the person administratively responsible for the agency. When a statement of deficiencies is sent out, the original letter and the statement of deficiencies is mailed to the operator. A copy of the letter and the statement of deficiencies is sent to the person administratively responsible for the agency to facilitate the development of the plan of correction.

2. Pre-Survey Activities

a. Pre-Survey Letter for Pre-opening Survey

Upon notification of approval of the application, the area office sends the pre-survey letter (Appendix A) to the applicant.

The requested materials should be returned to the area office within 60 days. If the materials are not received in that time, the agency is sent the follow-up letter. (Appendix B).

b. Pre-Survey Questionnaire for Resurvey

The Pre-Survey Questionnaire should be sent quarterly to the agencies scheduled for a full survey during that quarter as specified in the "Guidelines for Pre-Survey Questionnaire" in Appendix C. The Pre-Survey Questionnaire should be returned to the area office within 30 days of receipt.

3. Area Office Review

The survey process begins upon receipt of the requested materials. The first survey activity is the review of the following:

- Project application if this is the pre-opening survey;
- Area office file on the agency including any complaints received; and
- Materials submitted from the agency as listed in Appendix A, the Pre-Survey Letter or the Pre-Survey Questionnaire, (Appendix C).

Once the surveyor determines that the pre-survey materials are substantial compliance with the regulations, an on-site visit is scheduled. The initial survey may be announced, but subsequent full surveys are unannounced.

If additional information is necessary, the surveyor will contact the applicant by letter, telephone or meeting to effectively obtain this information. If the agency fails to submit the materials requested in the pre-survey letter, the area office must conduct a site visit and review such materials onsite to ascertain agency readiness to operate in compliance with departmental regulations within one year from date of approval.

The completed Pre-Survey Questionnaire is reviewed; an evaluation of this information may result in delaying the survey visit for another year (if the criteria for a three-year interval are met).

4. On-Site Activities

The on-site activities include a review of the operational aspects of care delivery. Activities include the following:

- Interview with administrative person;
- Resolution of issues related to the pre-survey materials;
- Observance of office space to ensure that it is adequate to provide for maintenance of confidential files and the availability of a communication system for 24 hours/even days per week coverage;
- Review of agency grievance/complaint log. This may include a telephone call to a small sample of complainants to ascertain their satisfaction with the handling/resolution of their complaint;
- Review of agency patient admission packet including patient bill of rights.
- Review of Quality Improvement Committee meeting minutes since the last full survey.
- Review of the active patient roster including services provided;
- Review of the discharged patients roster if there are insufficient active patients;
- Review of active personnel list including title and function;
- Review the agency policy regarding the frequency of clinical supervision;
- Review any agency policy and procedures that have been added or revised since the last survey.

- For full surveys other than the pre-opening survey, review and document to the Patient Record Review Form (Appendix O) a sample of patient care records including evidence of distribution of patients' rights.
 - Using the agency's list of patients, select five percent (5%) random sample of patient care records. Patient sample should exclude, whenever possible, patients serviced through contracts with Federal programs.
 - Review no more than 15 records or a minimum of two records for each trigger service and one for each other service provided unless the total patient census is below six. Should this be the case review all active records. Substitute up to five active records with closed records including patients discharged to a health care facility, by death, or to self care. Whenever possible use the agency's patient ID number to identify records reviewed.
 - If sample indicates problems, the surveyor should either cite deficiencies when the problem is clear or select a second sample of five records to obtain more information to verify the problem.
 - The Patient Record Review Form should be used to record survey results of the record review and as record identifiers.
- Review and document on the Personnel Record Review Form (Appendix P) a sample of personnel records as follows:
 - Using the agency's list of personnel, select a sample of five percent (5%) of personnel providing health care services, assuring representation of all health care services provided, preferably to patients whose records are reviewed. Select a maximum of 15 personnel records;
 - A minimum of one personnel record from each of the services the agency provides and from administration should be reviewed.
 - If the review of the minimal sample identifies concerns or deficiencies, an additional sample should be reviewed that includes, when applicable: (a) recently hired staff; (b) staff employed more than one year; (c) personnel providing service via contract; (d) staff recently resigned/terminated; and © staff providing care under contract.

5. Home Visits/Telephone Visits

a. Determination of Need for Home/Telephone Visits as Part of a Survey

At the time of survey, home/telephone visits are conducted on a sample of patients if:

- (1) the LHCSA is currently licensed and has multiple deficiencies in the areas of patients' rights, plan of care, medical orders, clinical supervision, and/or patient care records;
- (2) the agency has had three substantiated complaints registered against it by three different complainants within the past two years; or
- (3) to verify the agency's implementation of their grievance/complaint procedure after a review of the complaint log.

The decision to conduct an on-site home visit or telephone interview would be made by the surveyor and based on information available and on the purpose of the visit.

b. Patient Selection

If it is determined that home/telephone visits are necessary, select a sample of at least three patients for home visits from those patients whose records have been reviewed and which have deficiencies in one or more of the following areas: patient rights; patient service policies and procedures; plan of care; medical orders; clinical supervision and patient care records. Home/telephone visits to additional patients may be made if survey findings so warrant. An on-site home visit should be scheduled with agency staff.

c. Patient Consent

The patient should be contacted by telephone to obtain verbal consent to be visited. If the patient is reluctant, the possibility of rescheduling the visit at a later time may be discussed. The patient should be told that the information collected during the visit will be confidential to the extent that the Department will not divulge any patient information to any unauthorized party. Upon arrival, request that the patient sign the Home Visit Consent Form (Appendix D). If the patient refuses to sign the consent form but is willing to be interviewed, proceed with the visit. If upon arrival for a prearranged visit, then patient states the visit is no longer convenient, you may try to schedule another date but do not insist on conducting the visit.

d. Preparation for the Home/Telephone Visit

In preparing for the home/telephone visit, review the agency's clinical records, patient care plans, pertinent policies and procedures, and other relevant documents in order to perform a thorough comparison with what the surveyor observes and discusses in patients' homes or during a telephone interview. As part of the home/telephone visit process, the surveyor should:

- Ascertain whether services are rendered according to plan of care;
- Determine whether the plan of care reflects the patient's current status and is modified as the condition of the patient changes;
- Determine whether the number and frequency of supervisory visits reflects agency policy; and
- Determine whether supervisory visits are made to orient the aide to the plan of care; to provide required on-the-job training and to evaluate aide competency in the tasks performed.

e. Visit/Telephone Interview Procedure

In order to observe home care being given, attempt to schedule the home visits at a time when care is scheduled to be given, if possible.

At the patient's home, explain that the visit/telephone interview is part of a routine review of the agency providing home care, to ensure that the agency is providing the quality of care required by state regulations. Observations of care being given or interviews with the patient or staff are methods used to evaluate adequacy of care provided and patient satisfaction.

f. Documentation of Home/Telephone Visits

The number of home/telephone visits is entered on the Licensed Home Care Services Agency Survey Report (Appendix X). Identify home visit deficiencies by adding "HV" after the code identification number on the Statement of Deficiencies (DOH-1503).

6. Exit Conference

The purpose of the exit conference is to provide an opportunity to summarize and discuss both the positive and negative survey findings in order to facilitate the agency's understanding of code deficiencies.

In preparation for the exit conference, if more than one surveyor is surveying the agency, the survey team should meet to discuss the survey findings to make a determination on the deficiencies to be cited and the recommendations to be made. In making the determination on deficiencies to cite, the surveyor(s) should consider the number, nature and combination of findings, the presence of a pattern of patient care problems, the presence of a potential hazard to patient's health and safety, the severity of the survey findings and the resultant impact on patient care.

The exit conference is held with the agency administrator or designee and all other invited staff. The surveyor or team leader chairs the meeting. The exit conference agenda should include:

- A presentation of positive survey findings;
- A presentation of proposed code deficiencies;
- A presentation of agency practices that, if continued will result in code deficiencies;

- A presentation of the procedure of issuance of a statement of deficiencies and agency submission of a plan of correction;
- An opportunity for agency staff to provide additional information which negate the surveyor's findings;
- A response to agency questions;
- A presentation of the procedure for issuance of an initial license, if this is the initial survey.

The date of the exit conference is the last date of the onsite activities and is the "date of the survey" for any future reference to the survey.

7. Survey Report Form

The Licensed Home Care Services Agency Survey Report is completed to document specific information regarding the agency and the survey.

The Review of Personnel Form and the Patient Record Review Form are completed as documentation of the review of records during the survey process.

NOTE: It is extremely important to fully document cases that indicate a potential for enforcement action or denial of a license in order to substantiate the proposed action or decision made in the event of the hearing or court review.

8, Statements of Deficiencies

The purpose of the statement of deficiencies, documented on the Statement of Deficiencies and Plan of Correction, DOH-1503, (Appendix F) is to provide the agency with written notice of areas of agency functioning that are below acceptable parameters as established by State regulations. Each deficiency is a statement of a specific agency characteristic that does not meet a State regulation.

Each deficiency is written to accurately and clearly identify the problem and:

- is specific and draws a clear picture of what was observed;
- reflects a pattern of care from a representative sample;
- is concise, objective and quantifiable; and
- answers the questions: who, what, where, when, and how, when applicable.

An example of a correctly written deficiency is: "Ten out of 20 patient care records reviewed lack signed and dated progress notes by the physical therapist for biweekly visits conducted during the month of September. (10 NYCRR 766.6 (a) (5)) ."

The statement of deficiencies will support conclusions in the event of a hearing or court review. Since the statement of deficiencies is available to the public under the Freedom of Information Law, the following are not included:

- Patient names. I.D. numbers for patients and position titles for staff members are used in lieu of patient or staff names.
- Medical information about any identifiable patient;
- The identity of any informant who has given adverse information or has complaints about an agency;
- Information which could be considered defamatory toward any identifiable person; and
- The address of anyone other than the owner of the agency.

The deficiencies are documented on the left side of the Statement of Deficiencies and Plan of Correction, DOH-1053 and are grouped and titled according to the corresponding sections of 10 NYCRR. Following each deficiency, the specific reference for the state regulation is recorded (i.e., 10 NYCRR 766.1(a)). The statement of deficiencies is transmitted to the agency attached to the form letter for transmitting the Statement of Deficiencies (Appendix G), within 10 days of the survey.

If no deficiencies are found, and the agency is in compliance with all regulations, the form letter for Transmitting Compliance with the Regulations (Appendix H) is used to transmit this information to the agency.

If the agency was not fully operational at the time of the survey, the following statement is written on the statement of deficiencies: “This agency has not yet accepted patients for care, therefore, the regulations could not be adequately judged.” These regulations are to be evaluated during the post-approval visit.

9. Plan of Correction

The plan of correction is the agency’s plan of corrective actions to be taken to bring the agency into compliance for each deficiency cited. The agency will document the plan of correction on the Statement of Deficiencies and Plan of Correction, DOH-1053, and return it to the area office within 10 days of receipt of the statement of deficiencies. When the plan of correction is received in the area office, the surveyor reviews it to determine its acceptability. An acceptable plan of correction will include:

- Steps to be taken to correct the cited deficiency;
- Steps to be taken to prevent future occurrence of a cited deficiency;
- Person(s), identified by position, responsible for the correction;

- Anticipated completion date for achieving correction of each deficiency.

If deemed acceptable, the surveyor recommends acceptance of the Plan by initiating and dating each item. The Regional Home Care Program Director reviews the recommendation and notifies the Operator of this acceptance with the form letter in Appendix I. If the surveyor determines that a portion of (or the entire) Plan of Correction is unacceptable, the unacceptable portion is documented in a separate report for review by the program director. This report is sent to the agency attached to the form letter for Transmitting Unacceptable Plan of Correction, (appendix J) notifying the Operator of the unacceptable Plan of Correction and requesting an amended Plan. This letter is sent within 10 days of the receipt of the original Plan. An amended Plan of Correction is returned to the area office within 10 days of the receipt of the letter. This sequence continues until an acceptable Plan of Correction is obtained. It may be advisable to have a meeting with the operator to reduce the number of multiple written requests and responses.

After two unacceptable Plans have been submitted, depending on the seriousness of the deficiencies, the regional office may consider recommending to BHHCS implementation of possible enforcement action.

10. Post Survey Review

When an amended plan is acceptable (original plus amendments), the Operator is notified using the form letter for Transmitting Acceptable Plan of Correction (Appendix I). The purpose of conducting the post-survey review is to verify that the corrective actions documented in the Plan of Correction were taken to bring the agency into compliance with the regulations. In some cases, an on-site visit may not be required and a mail or telephone contact with the agency will suffice, e.g., in the areas of bylaws or policies and procedures. However, if the information reported by telephone or mail does not validate that the correction is adequate, an on-site visit to the agency must be made.

When an on-site visit is required to verify that the corrective actions were taken, the survey process is followed. For example, if personnel records did not meet the regulations on survey, the surveyor will measure the agency's compliance with personnel requirements during the post-survey review by conducting another personnel record review.

For those agencies that were not fully operational at the time of the initial survey, an on-site visit is conducted to evaluate compliance with the regulations not addressed by the initial visit. The post-survey visit should be conducted no later than six to nine months after the survey.

The results of the post-survey review are documented on the Post Certification/approval Revisit Report, DOH 1504, (Appendix K). The number of the deficiency is listed in the left column under "Item No." The surveyor records the status of correction of the deficiency and a brief description of the findings under Present Status". For example:

- Item No. 3 Deficiency: "Of the 10 personnel records reviewed, five records do not contain health assessments."
- At the post-survey visit, the status is documented as follows on the Post Certification/Approval Revisit Report (Appendix K):

- Item No. 3 Corrected – 10 personnel records reviewed. Nine records contained health assessments. One record had no assessment. The RN is following up on employee bringing in health assessment statement.

11. Transmitting Survey Records

The post-survey review should be conducted no earlier than the target date(s) in the Plan of Correction and no later than six to nine months after the survey unless major patient care concerns require a more timely visit. Survey packets are sent to the Bureau of Home Health Care Services within 10 days when:

- A survey is completed and there are no deficiencies;
- A survey is completed, Statement of Deficiencies has been issued and the Plan of Correction is accepted; or
- The post-survey is completed.

The following materials are to be included in the survey packet:

- License Home care Services Agency Survey Report;
- Statement of Deficiencies and Plan of Correction;
- Amended Plan(s) of Correction, if applicable; and
- Post Certification/Approval Revisit Report
- Any documentation that supports change in ownership, d/b/a, legal status since original licensure approval or last survey, if applicable.

C. Licensure Activities

5/12/98

1. Protocols for Issuance or Revision of a Home Care Services Agency License

The Licensed Home Care Services Agency Transaction Notice is used to electronically transmit the required information to the Bureau of Project Management (BPM) so that an initial or amended home care agency license will be issued. This form is accessed in Lotus Notes by first selecting Healthcom on Notes, then DOH forms, then General Department Forms (Mini Forms) and lastly HHL.

2. Initial License

There must be a memorandum from the Division of Legal Affairs in the file stating the application is legally sufficient before the pre-organizing survey is conducted. When the pre-opening survey process is complete and the agency is determined to be in substantial compliance, the license transaction notice is electronically transmitted to BPM. Prior to issuance of a license, the area office may give permission to the agency to admit patients. Directions for the completion of the license transaction notice are in Section C-7. In order to complete the notice the Public Health Council (PHC) final approval letter and the Character and Competence Staff Review will be required. The name of the agency to be shown on the license must be the same as the name or the assumed name shown on the Public Health Council approval letter. If the name that the agency proposes during the survey process is different from the approved name, and executed certificate of amendment to the certificate of incorporation, stating that the name of the corporation has been changed, or a certificate of doing business under an assumed name, that has been duly filed, is required. It should be noted that regulations require the operator to submit a written request for the approval of a change of name prior to implementing that change. Any change in type of ownership from that listed on the staff review requires additional Public Health Council approval. A license cannot be issued without the federal tax ID number for the agency being entered on the license transaction notice.

NOTE: A copy of the pre-opening survey packet is forwarded to the Bureau of Home Health Care Services (BHHCS).

3. Additional Site

A license for an additional site of an existing agency will require the completion of a license transaction notice as outlined in Section C-7. The project/application number and ownership information can be obtained from the transaction notice for the existing site.

4. Change of Ownership – Simple Change of Operator

The area office will determine if there is a need to conduct a pre-opening survey. The Federal tax ID number should be verified. The transaction notice is completed as outlined in section C-7. The effective date of the license will be the actual date that the ownership changed of if the change took place prior to receiving Public Health Council approval, the date of the PHC approval. The transaction notice is electronically submitted to both BPM and BHHCS for changes of ownership. In order for the completed form to be forwarded to BHHCS it must be saved prior to sending to PMU. It can be forwarded to BHHCS from the in-basket in Notes.

5. Change of Ownership – Acquisition or Merger

The license transaction notice is completed as for a simple change of operator with the additional requirement that the license number of the acquiring agency be entered on the form as outlined in section C-7. The Federal tax ID number should be verified.

6. Revision (Amendment) of a License

Submission of a license transaction notice is required if any of the following has occurred:

- A change in service area;
- The addition or deletion of any services; or
- A change in the name or address of the agency and/or operator.

When an agency wishes to add nursing, home health aide or personal care services, an application is submitted to the regional office at least 90 days prior to the anticipated start of service to obtain written approval from the department. Within 90 days of the receipt of the application, the regional office will review the information provided and may conduct a partial survey to determine agency compliance with the regulations.

When an agency wishes to add or delete any of the other health care services, written notification is made to the regional office at least 30 days prior to commencing or discontinuing physical therapy, occupational therapy, speech/language pathology, nutrition services, social work, respiratory therapy, physician services, or medical supplies, equipment and appliances.

When an agency wishes to change its address, written notification is made to the regional office at least 10 days prior to the change. A DOH 1502E Transaction Form is completed, indicating whether the change applies to the agency, the operator, or both.

If the agency is in compliance with the regulations, the regional office will complete a transaction notice as outlined in section C-7 of this document and electronically transmit the transaction notice to BPM.

7. Completion of the Licensed Home Care Services Agency Transaction Notice

In order to complete the transaction notice the Public Health Council (PHC) final approval letter and the Character and Competence Review Staff will be required. The name of the agency to be shown on the license must be the same as the name or the assumed name shown on the Public Health Council approval letter. If the name that the agency proposes during the survey process is different than the approved name, an executed certificate of amendment to the certificate of incorporation, stating that the name of the corporation has been changed, or a certificate of doing business under an assumed name, that has been duly filed, is required. It should be noted that regulations require that the operator submit a written request for the approval of a change of name prior to implementing that change.

The license transaction notice form is accessed in Lotus Notes by first selecting Healthcom on Notes, then DOH Forms, then General Department Forms (Mini Forms) and lastly HHL.

NEW LICENSE

SECTION A

- Click on New in the drop down box in Section A of the transaction notice and enter the application number in the appropriate space.

- Enter the effective date of the new license. This is the date the agency is determined to be in compliance with the regulations.

SECTION B

- Click on Proprietary Corporation, Voluntary Corporation, Partnership, Individual or Public. This information is found on the top portion of the Character and Competence Staff Review. Any change in type of ownership from that listed on the staff review requires additional Public Health Council approval.

SECTION C

- Agency Name – The name of the operator, which is either a corporation name, the individual names of partners of the individual owner’s name, is entered.
- Approved DBA – Enter the name under which the agency is doing business if this name is different from line one.
- Address – Enter the address of the site including the county in which the site is located and the telephone number and enter the Federal ID Number.
- Services – Click on Add then click on each of the services in the drop down box to be provided by the agency.
- Service Area – In the drop down box, click on Add then click on the names of the counties to be served by the agency.

SECTION D

- Enter the name of the person authorizing the transaction and click on the name of the area office in the drop down box.

NOTE: A copy of the pre-opening survey packet is forwarded to the Bureau of Home Health Care Services (BHHCS).

ADDITIONAL SITE

A license for an additional site of an existing agency will require completion of a license transaction notice following all the steps of initially licensing an agency with the exception that you click on Additional Site in Section A. The project/application number and ownership information can be obtained from the transaction notice for the existing site(s).

CHANGE OF OWNERSHIP – SIMPLE CHANGE OF OPERATOR

The transaction notice is completed for the issuance of a new license with the exceptions of clicking on Change of Ownership on the form’s Section A and the inclusion of the seven digit license number of the existing agency. The effective date of the license will be the actual date that the ownership changed or if the change took place prior to receiving Public Health Council approval, the date of the PHC approval.

The transaction notice is electronically submitted to both BPM and BHHCS for changes of ownership. In order for the completed form to be sent to BHHCS it must be saved prior to sending it to PMU. It can then be forwarded to BHHCS from the in-basket in Notes.

CHANGE OF OWNERSHIP – ACQUISITION OR MERGER

The transaction notice is completed as for a simple change of operator with the additional requirement that, if the acquiring entity is currently operating as a LHCSA, its license number must be entered on the form in Section A.

REVISION (AMENDMENT) OF A LICENSE

- The agency must be in compliance with the regulations when the regional office transmits the transaction notice, which must include a completed Section A containing the information on the existing license.
- In Section C, enter the name of the agency as well as the actual item(s) presently on the license and the revision to be made as follows:

✓ Change of Name:

Indicate by clicking on Agency, Operator, or Agency/Operator to indicate if the change is to the name of the agency, the operator or both.

Enter the present name of the agency/operator in the current column and the new name in the change column.

✓ Change of d/b/a:

Click on Agency.

Enter the existing d/b/a in the current column or, if there is none, enter “none”.

Enter the new d/b/a in the change column.

✓ Change of Address:

Indicate by clicking on Agency, Operator, or Agency/Operator to indicate the change is to the address of the agency, the, the operator, or both.

Enter the present address of the agency/operator in the current column and the new address in the change column.

✓ Addition/Deletion of Services:

Click on Add or Delete in the drop down box, then click on the county name(s).

- Complete Section D and electronically transmit the license transaction notice to BPM.

D. EXPANSION ACTIVITIES

1. **Approval of New Sites**

Area Office approval is required prior to opening new service delivery sites. Decisions regarding the need for conducting pre-opening site visits and/or subsequent visits to review clinical records of such expansions are at the Program Director's discretion. Each office site from which the patient care services are delivered should receive a separate license.

When the Area Office receives an inquiry from a Public Health Council approved Operator requesting to open an additional site, the Area Office sends out Application/Pre-Survey New Site, (Appendix M) requesting the submission of the LHCSA application (pages 2-6), the pre-survey checklist, (Appendix N) and/or materials. The Operator has 30 days to submit the requested information and materials to the Area Office. If the requested pre-survey materials are identical to those submitted for an existing agency or to another Area Office, it may not be necessary to resubmit these materials for review.

Within 90 days of receipt of the application and pre-survey materials the Area Office will review and act upon the application. This process includes:

- contact with other Area Office surveyors having sites of the same Operator to ascertain acceptability of pre-survey materials, results of the onsite surveys and agency track record, i.e., complaints or to request these materials for review;
- review of submitted pre-survey materials to determine level of acceptance of materials that have not been reviewed by another Area office or may differ from those previously submitted;
- conduct of onsite surveillance activities in accordance with the surveillance process for LHCSAs;
- issuance of the statement of deficiencies for areas of non-compliance;
- recommendation of issuance of a license when the plan of correction is acceptable and agency is in compliance;
- notification to the agency to become operational; and
- a post-survey visit conducted when the agency has a patient caseload sufficient to evaluate the patient care components of the regulations.

2. **Geographic Service Area/Exceptions**

A LHCSA's geographic service area must be limited to ensure the quality of home care services when recommending licensure and reviewing proposed geographic area expansions. The geographic area served by a single LHCSA site is generally limited to the geographic boundaries of each Area Office of the Office of Health Systems Management in which services are provided with the following exceptions:

- The Department will permit a LHCSA site to provide services "in one additional county" within the jurisdiction of another Area Office without being required to open another site of service delivery in that region at the discretion of the two Area Offices having jurisdiction. The "one additional county" must be contiguous to the geographic boundaries of the Area Office in which the LHCSA site is located, but need not be contiguous to the specific county in which the LHCSA site is located. For example, an agency site located in Westchester County and serving all counties within the geographic boundaries of the New Rochelle Area Office may also service Greene County, located in the Northeastern Area. Greene County is contiguous to the New Rochelle Area Office geographic boundaries but is not contiguous to Westchester, the county in which the service delivery site is located. If a LHCSA wants to provide services in more than one county within the geographic boundaries of an additional Area Office, there must be at least one delivery site serving the counties within the geographic boundaries of that Area Office.
- The Department will also permit Home Infusion LHCSAs to serve up to 35 patients at any one time in an OHSM Area adjacent to the Area in which the site is located. For the purpose of this exception, a Home Infusion LHCSA is defined as a LHCSA whose services are strictly limited to home infusion therapy and whose only home care personnel are nurses with the sole responsibility of providing technical assistance and monitoring of infusion therapy procedures. It is assumed that a Home Infusion LHCSA wishing to extend its services in this way has already received approval of the two Area Offices involved to provide its services within one contiguous county beyond the OHSM area in which its site is located. The adjacent OHSM Area in which the up to 35 additional patients reside must be the same Area as that in which the contiguous county need not be counted in the 35. A Home Infusion LHCSA wishing to serve patients in more than two OHSM Areas must establish additional service sites as appropriate.

(Initial policy developed 10/89; revised 10/91)

F. ACRONYMS, ABBREVIATIONS and DEFINITIONS

12/91

Agency	-Licensed home care services agency or an applicant to become a licensed home care services agency.
Agency Administrator	-Title used throughout the surveillance process to refer to the person administratively responsible for the agency.
Branch Office	- A site from which the health care services are provided. Each site of service delivery will be licensed. Administrative control may be received from the principal administrative office (PAO), if the branch office is sufficiently close to receive administrative oversight on a daily basis. In this instance, each branch office is surveyed and licensed in conjunction with the PAO and together all regulations are met. The branch office and PAO are to be in compliance with the sections of the regulations that correspond to their function.
Date of Survey	- This is the last day of the survey; the date of the exit conference.
Department	- New York State Department of Health
LHCSA	- Licensed Home Care Services Agencies
License	- The document that authorizes the agency to operate in the State of New York.
Operator	- The policy making body of a government agency, the board of directors or trustees of a corporation or the proprietor or proprietors of the proprietary facility, agency or program to which the department has issued a license.
POC	- Plan of Correction
BHHCS	- Bureau of Home Health Care Services

Licensed Home Care Services Agencies
Surveillance Process

BPM

- Bureau of Project Management

Principal Administrative Officer

- The office that develops and maintains administrative control of one or more branch offices on a daily basis (see Branch Office). The PAO may also be the site from which health care services are delivered. In this instance, this office independently meets all licensure regulations and is a LHCSA.

SOD

- Statement of Deficiencies

Survey Results

- The notice to the provider that defines the results of the survey. The notice will be either a letter stating the agency is in substantial compliance with 10 NYCRR or a statement of deficiencies.

10 NYCRR

Title 10 of the New York Codes, Rules and Regulations

G. APPENDICES

5/12/98

- A. Form Letter: Pre-Survey Letter
- B. Form Letter: Follow-Up Letter
- C. Pre-Survey Questionnaire
- D. Home Visit Consent Form
- E. Licensed Home Care Services Agency Survey Report
- F. Statement of Deficiencies and Plan of Correction, DOH-1503
- G. Form Letter: Transmitting the Statement of Deficiencies
- H. Form Letter: Transmitting compliance with the regulations
- I. Form Letter: Transmitting acceptable plan of correction
- J. Form Letter: Transmitting unacceptable plan of correction
- K. Post Certification/Approval Review Report, DOH-1504
- L. License Transaction Notice (BPMLTN)
- M. Form Letter: Application/Pre-Survey New Site
- N. Pre-Survey Checklist
- O. Patient Record Review Form
- P. Personnel Record Review Form

FORM LETTER; PRE-SURVEY LETTER
USE REGIONAL/AREA OFFICE LETTERHEAD

Name of Operator
Street
City, State, Zip Code

RE: Project Number:
Agency Number
Reply Required by:

Dear Operator:

Prior to the issuance of a license for your agency, an initial survey will be conducted by the staff of
_____ .

To begin this survey process, please submit to the _____ Office at the above address, the following requested information and materials within sixty (60) days of receipt of this letter.

- Names, addresses, and telephone numbers of all offices (principal administrative and branch) including directions to each site of service delivery;
- Name and title of person administratively responsible for each site;
- Name of registered professional nurse(s) responsible for direction and supervision of patient care and health services including a copy of current New York State Registered Professional Nurse license(s);
- Responsibilities (rules and by-laws) of the Governing Authority;
- Rules and by-laws of quality improvement and any other committee;
- Names and titles of the members of quality improvement and any other committee;
- Copies of contracts and agreements;
- Federal Tax identification number;
- Job description for each position;
- Materials available to public and agency;
- Patient Bill of Rights;
- Clinical record forms;
- Personnel record forms;
- Policies and procedures as they pertain to 10 NYCRR Parts 700, 765, and 766 for:
 - X Revisions to license
 - X Personnel;
 - X Patient Rights;
 - X Advanced Directives;
 - X Admission, retention, and discharge of patients;
 - X Clinical Records;
 - X Care of medical supplies, equipment and appliances;
 - X Orientation of staff;
 - X Supervision of home health aides and personal care aides;
 - X Emergency/disaster preparedness plan;
 - X Patient complaints/grievances

Appendices

Licensed Home Care Services Agencies
Surveillance Process

- X HIV confidentiality; and
- X Advanced directives.

After this material is reviewed, a date for the onsite portion of the survey will be scheduled with you.

The regulations governing licensed home care services agencies are found in Parts 700, 765 and 766 of Volume Ten of the New York Code of Rules and Regulations (10NYCRR). Attached is a list of Department of Health Memoranda (DOHMs) that may be helpful in developing your policies and procedures as well as the telephone number of information on acquiring these documents.

If you any questions about this process, please contact

_____ at _____.

Sincerely,

Name
Regional Administrator or Designee

Appendices

Licensed Home Care Services Agency Regulations (Parts 700, 765 and 766 of 10 NYCRR) can be purchased from:

West Group
620 Opperman Drive
P.O. Box 64779, D-5-10
St. Paul, Minnesota 55123-4779
(800) 328 4880

Department of Health Memoranda (DOHMs) can be obtained by contacting the Records Access Office at (518) 474 8734. The numbers and titles of pertinent memoranda are as follows:

- 96-17 Updated Information on the Management of Occupational Exposure to Human Immunodeficiency Virus (HIV)
- 95-14 Supplemental Infection Control Guidelines for the Care of Patients Colonized or Infected with Vancomycin-Resistant Enterococcus (VRE) in Hospitals, Long Term Care Facilities and Home Health Care.
- 94-21 Recent Legislation Affecting Home Care
- 94-32 Recommendations for the Management of Communicable Diseases among Employees in Health Care Facilities
- 92-03 Advanced Directives
- 92-24 Home Health Aide Scope of Tasks
- 92-25 Complaint Investigation in Home Care
- 92-32 DNR Law Changes
- 91-11 Patient Confidentiality
- 91-18 Provision of Medical Equipment and Appliances
- 91-56 Patient Confidentiality
- 90-01 Recommendations for the Prevention and Management of Bloodborne Disease Transmission in Home Care Setting
- 89-72 Role of Licensed Practical Nurses in Intravenous Therapy Procedures

**FORM LETTER: FOLLOW-UP LETTER
USE REGIONAL/AREA OFFICE LETTERHEAD**

Name of Operator
Street
City, State, Zip code

Re: Agency Name Follow-up to
Requested Materials

Reply Required by:

Dear Operator:

Prior to the issuance of a license to your agency, you were requested to submit certain materials to the _____ Office so that an initial survey could be conducted.

These materials have not been received. You are therefore, requested to either submit these materials within 10 days of receipt of this letter or contact (Name, Title, Telephone Number) within that time frame to discuss your survey schedule.

If you have any questions about this process, please contact me at _____ .

Sincerely,

Name
Regional Administrator or Designee

cc. Agency Administrator

Appendices

**NEW YORK STATE DEPARTMENT OF HEALTH
HOME CARE PRE-SURVEY TOOL
LICENSED HOME CARE SERVICES AGENCY**

General Instructions

All licensed home care agencies (LHCSAs) are required to submit the attached Home Care Pre-Survey Tool to the New York State Department of Health. This form will be used as a data source document for determining compliance with Article 36 as a Licensed Home Care Services Agency.

The following instructions are to be followed:

1. Please read and carefully follow any specific instructions provided for each question.
2. Complete questions in accordance with the response options offered. Supply additional information only when requested or if necessary to clarify and/or explain your response to that question.
3. Please use ink or type your response. Unless otherwise specified, response with a check mark or an "X" in the appropriate space.
4. The report period covered by this form shall be for the period from the last full survey to the present. The date of the last survey is provided on page 3. Please use this date when completing questions requesting information for the time period of the last survey.
5. If more space is required, attach additional sheets on which the agency name, page number and heading of the question are clearly specified.
6. The Home Care Pre-Survey Tool and accompanying documents should be returned within thirty (30) days of receipt to the area office of the State Department of Health from which it was sent. Failure to promptly submit this report may result in the issuance of a statement of deficiencies to the agency. The area office should be contacted if there is a need for an extension of the deadline for submission.

TO BE COMPLETED BY REGIONAL OFFICE

Agency Name _____

Agency Address _____

City/County/State/Zip _____

License Number _____ Date of last full survey _____

Counties for which this tool should be completed _____

TO BE COMPLETED BY AGENCY

I. ORGANIZATION AND ADMINISTRATION

766.9

A. Descriptive Information

1. Specify the counties served by the agency _____

2. Legal structure of agency (check one)

Individual _____ For profit corporation _____

Partnership _____ Not for profit corporation _____

Other _____

3. Attach an organizational chart.

4. Specify the name and location of each office site under your core licensure number, if any, located within the counties listed in item 1 above.

<u>License Number</u>	<u>Agency Name</u>	<u>Agency Location</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Appendices

Licensed Home Care Services Agencies
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5. Has ownership changed since last survey? YES _____ NO _____
If yes, describe the transaction. _____

Date of this change _____
6. Is the agency accredited? YES _____ NO _____
If yes, identify the accrediting body. CHAP _____ JCAHO _____
OTHER _____
Please attach a copy of the most recent accreditation visit report.
7. What is the current patient census of your agency? _____
8. What was the number of unduplicated patients served for the last calendar year
at this site? _____
9. What type of services are primarily provided from this site? If your case mix includes more
than one service, please approximate the number of each service provided:
- _____ Nursing
 - _____ Pediatric Nursing
 - _____ IV Nursing
 - _____ Ventilator Nursing
 - _____ Physical Therapy
 - _____ Occupational Therapy
 - _____ Respiratory Therapy
 - _____ Speech/Language Pathology
 - _____ Medical Social Work
 - _____ Paraprofessional Services
 - _____ Other (Please specify) _____
10. Does this site operate a home health aide training program? _____ Yes _____ No

Appendices

B. Services Provided

766.2

For each service listed on the agency’s license, check the appropriate space below whether the service is offered and/or under contract arrangement as follows.

- Check “Directly” if the service is provided through salaried employees.
- Check “Under Contract Arrangement” if service is provided through contracted arrangement with other agencies, organizations or individuals.

In the column headed “Added Since Last Survey” indicate the manner in which the service is being provided by writing “**D**” for “Directly” and/or “**UCA**” for “Under Contract Arrangement”. This column should be completed only for those services which appear on the license or for which final approval has been obtained.

<u>Service Provided</u>	<u>Under Contract Directly</u>	<u>Added Since Arrangement</u>	<u>Last Survey</u>
Nursing	_____	_____	_____
Home Health Aide	_____	_____	_____
Personal Care	_____	_____	_____
Medical Supplies, Equipment and Appliances	_____	_____	_____
Medical Social Work	_____	_____	_____
Nutrition Services	_____	_____	_____
Occupational Therapy	_____	_____	_____
Physical Therapy	_____	_____	_____
Speech/Language Pathology	_____	_____	_____
Physician Services	_____	_____	_____
Respiratory Therapy	_____	_____	_____
Other	_____	_____	_____

C. Governing Body

766.9

1. List names and title of directors and officers of the governing body of the LHCSA.

<u>Name</u>	<u>Title</u>
_____	_____
_____	_____
_____	_____
_____	_____

2. How often does the governing body meet? _____

3. The most recent meeting of the governing body was held on _____

4. Do written policies indicate that the governing authority:	<u>YES</u>	<u>NO*</u>
a. ensures responsibility for the management and operation of the agency?	_____	_____
b. ensures compliance of the home care services agency with all applicable federal, state and local statutes, rules and regulations?	_____	_____
c. ensures the prompt submission of all records and reports as required by the department?	_____	_____
d. adopts and approves amendments to written policies regarding the management and operation of the home care agency?	_____	_____
e. adopts and approves amendments to written policies concerning the provision of health care services?	_____	_____
f. makes available to the public information concerning the services that it offers, and the geographic area in which these services are made available?	_____	_____
g. employs or contracts for a sufficient number of staff to coordinate, direct, or deliver services to patients accepted for care in accordance with prevailing standards of professional practice?	_____	_____

Licensed Home Care Services Agencies
Surveillance Process

	<u>YES</u>	<u>NO*</u>
h. employees at least one registered professional nurse to be responsible for the direction and supervision of all patient care services and other health care activities of the agency?	_____	_____
i. accepts and retains for services only those persons whose health care needs can be safely and adequately met by the agency according to criteria specified in written agency policies?	_____	_____
j. ensures the development of a patient grievance or complaint procedure?	_____	_____
k. appoints a quality improvement committee to establish and oversee standards of care?	_____	_____
l. reviews all policies and procedures annually?	_____	_____
5. Regulations require an emergency and disaster plan.		
a. Is an emergency and disaster plan currently in effect?	_____	_____
b. Does the plan provide for each of the following incidents:		
1. civil disturbance (e.g., labor action involving agency/ program employees or employees of other health care provider(s) in the community?	_____	_____
2. transportation stoppage	_____	_____
3. natural disaster (e.g., fire, blizzard, power failure)?	_____	_____
c. Does the plan specify procedures, direction, and/or provision for each of the following:		
1. care of patients?	_____	_____
2. communication and notification to employees, patients, physicians, and significant others	_____	_____

	<u>YES</u>	<u>NO*</u>
c. Does the plan include each of the following informational lists:		
1. key staff including designated alternates as appropriate with home address, telephone numbers, and emergency related responsibilities?	_____	_____
2. unions have contracts with the agency/program and termination dates of contracts including numbers and types of employees?	_____	_____

For each “No” response, indicate below the question number and provide a brief explanation.

<u>Question Number</u>	<u>Explanation</u>
_____	_____
_____	_____
_____	_____

D. General Policies and Procedures
766.2

Indicate if written policies and procedures for the following areas have been developed, the status of annual review, and as, appropriate, revision. Complete columns for each service listed on the agency’s license, whether the service is provided directly under contract arrangement. Then proceed with completion of all remaining questions. Attach a copy of all new and/or revised policies and procedures implemented since the agency’s last full survey.

Licensed Home Care Services Agencies
Surveillance Process

	<u>Policy/ Procedure Present? Yes/No</u>	<u>Date of Most Recent Review by the Governing Authority</u>	<u>Revised Since Last Survey? Yes/No</u>	<u>Not Applicable</u>
Nursing Service	_____	___/___/___	_____	_____
Home Health Aide Service	_____	___/___/___	_____	_____
Personal Care Services	_____	___/___/___	_____	_____
Medical Supplies, Equipment & Appliances	_____	___/___/___	_____	_____
Medical Social Work	_____	___/___/___	_____	_____
Nutrition Services	_____	___/___/___	_____	_____
Occupational Therapy	_____	___/___/___	_____	_____
Physical Therapy	_____	___/___/___	_____	_____
Speech/Language Pathology Service	_____	___/___/___	_____	_____
Physician Services	_____	___/___/___	_____	_____
Respiratory Therapy	_____	___/___/___	_____	_____
Patient Admission	_____	___/___/___	_____	_____
Patient Discharge	_____	___/___/___	_____	_____
Medical Orders	_____	___/___/___	_____	_____
Authorized Practitioner Notification of Change in Patient Status	_____	___/___/___	_____	_____
Service Charges	_____	___/___/___	_____	_____
Clinical Supervision	_____	___/___/___	_____	_____
Performance Evaluation of Staff	_____	___/___/___	_____	_____
Personnel Qualifications	_____	___/___/___	_____	_____
Personnel Identification	_____	___/___/___	_____	_____
Employee Health Requirements	_____	___/___/___	_____	_____
Patient Care Record	_____	___/___/___	_____	_____
Patient Grievance Procedure	_____	___/___/___	_____	_____
Quality Improvement Committee	_____	___/___/___	_____	_____
In-Service Requirements:				
- Home Health Aides	_____	___/___/___	_____	_____
- Personal Care Workers	_____	___/___/___	_____	_____
Emergency/Disaster Plan	_____	___/___/___	_____	_____
Patient Rights	_____	___/___/___	_____	_____
HIV/Infection Control Policies & Procedures	_____	___/___/___	_____	_____
HIV Confidentiality Education	_____	___/___/___	_____	_____
Policy for LPN Performance of IV Therapy (if applicable)	_____	___/___/___	_____	_____
DNR	_____	___/___/___	_____	_____
Advance Directives	_____	___/___/___	_____	_____

Appendices

III. CONTRACTS

A. Contract Components

766.10

	Contract Arrangement With Another Agency or Organization?		Personnel Under Hourly Or Per-Visit Contract?	
	Yes	No*	Yes	No*
	<p>1. If services are provided under contract arrangement With another agency or organization, and/or if personnel Under hourly or per visit contract are utilized, are the Responsibilities, functions, objectives and terms of Agreement:</p> <p style="margin-left: 20px;">a. defined by writing?</p> <p style="margin-left: 20px;">b. signed by an authorized representative of your agency</p> <p style="margin-left: 20px;">c. signed by the contracting party/</p> <p style="margin-left: 20px;">d. currently in effect?</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>2. Does each agreement clearly designate responsibility of your agency for:</p> <p style="margin-left: 20px;">a. acceptance of patient for care?</p> <p style="margin-left: 20px;">b. services rendered to patients?</p> <p style="margin-left: 20px;">c. control, coordination and evaluation of services?</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>
<p>3. Are procedures/policies stated in each arrangement for:</p> <p style="margin-left: 20px;">a. specific services to be provided?</p> <p style="margin-left: 20px;">b. examination of personnel records of subcontracting provider to determine personnel qualifications?</p> <p style="margin-left: 20px;">c. submission of clinical and progress notes?</p> <p style="margin-left: 20px;">d. determination of charges and reimbursement?</p> <p style="margin-left: 20px;">e. "Not withstanding" clause (766.10 (d))?</p> <p style="margin-left: 20px;">f. access of physician orders, nursing assessment, social work notes, and personnel in contracts with DSS and CHHA?</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>4. Is there a description of how the above information can be obtained?</p>	<p>_____</p>	<p>_____</p>	<p>_____</p>	<p>_____</p>

Appendices

- For each “NO” response, indicate the question number and the name of the subcontracting provider(s) under contract arrangement to which the “NO” applies.

Question Number

Name of Contracting Provider(s)

B. Contract Arrangements with Agencies of Organizations

For all services provided under contract with another agency or organization, list each agency, organization, or individual, and the service(s) provided under contract arrangement.

Name of Agency/Organization

Service(s) Provided

Appendices

IV. **QUALITY IMPROVEMENT COMMITTEES**
766.9(K)

This section is designed to obtain information about the composition and activities of the Quality Improvement Committee.

A. **Quality Improvement Committee**

<u>Name of Individual</u>	<u>Title/Discipline Organization Representation</u>	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	<u>Yes</u>	<u>No</u>
1. Since the last survey, has the Quality Improvement Committee met? Specify frequency of meetings _____	_____	_____
2. Has the composition of the quality improvement committee changed Since last survey?	_____	_____
3. Are meetings documented by dated minutes?	_____	_____
4. Does the Quality Improvement Committee:		
a. review policies pertaining to the delivery of health care services provided by the agency?	_____	_____
b. recommended changes in such policies to the governing authority for adoption?	_____	_____
c. identify problems, develop solutions, and monitor outcomes?	_____	_____
conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes:		
• random selection of patients currently receiving services?	_____	_____
• random selection of patients discharged within 3 months?	_____	_____
• all records with identified patient complaints?	_____	_____
5. Please attach Quality Improvement Committee meeting minutes And/or any studies related to quality improvement conducted by Your agency within the last year.		

V. PATIENT CARE RECORDS

A. Patient Care Record Protection and Retention

766.6(b)

YES NO

1. Are patient care records retained for six (6) years after discharge
 Of the patient, or in the case of minors, six (6) years after the
 The patient's majority? _____

2. Location of closed records _____

B. Records and Reports

766.12

YES NO NA

Does the governing authority have policy to ensure:

- that the contracts and other agreements related to the delivery of patient care are retained at the Principal Administrative Office in New York State? _____
- the retention of meeting minutes of the governing authority and the committees thereof for three years? _____
- the retention of records of all financial transactions directly related to delivery of patient care for three years? _____
- retention of personnel records for three years from the date of employee termination or resignation? _____
- retention of records of written grievances and complaints for three years from date of resolution? _____

Explanation and Abbreviations

State References

10NYCRR: Title 10 (Health) Part 766 Volume C, Official Compilation of Codes, Rules and Regulations of the State of New York.

APPENDIX D

DOH Letterhead

Consent for Home Visits

This consent statement allows New York State Department of Health home health care survey staff to make a home visit as part of a survey or complaint investigation. I understand that my participation is voluntary and that a refusal will not affect future delivery of services. I agree to answer truthfully the questions the surveyor asks and understand that all information provided will be kept confidential.

Name of Agency

Name of Patient

Address of Agency

Surveyor's Name & Title

Patient's Signature

Date

If patient is unable to sign (child or disabled), a significant other may sign and note the relationship.

Appendices

APPENDIX E

**NEW YORK STATE DEPARTMENT OF HEALTH
LICENSED HOME CARE SERVICES AGENCY
SURVEY REPORT**

Name of Agency _____

Address _____

City _____ County _____

License Number _____ Telephone Number _____

Operator Name _____

Address _____

City _____ Telephone Number _____

Counties Served: _____

Services Provided: _____

Responsible RN: _____ License # _____

Administrator/Owner _____

Accredited: JCAHO CHAP Other N/A Federal ID Number _____

Change in Ownership _____

Current Patient Census _____

Current Survey Dates: _____ Previous Survey Dates: _____

Type of Survey: Pre-opening Additional Service Site Full Partial

Number of Survey Days: _____ Number of Surveyors: _____ Number Home Visits: _____

Surveyor: _____ Title _____

Surveyor: _____ Title _____

APPENDIX F

Statement of Deficiencies and Plan of Correction, DOH-1503

This Appendix is a Form
that is unavailable in electronic format.
It will be available to the successful bidder.

APPENDIX G

**FORM LETTER: TRANSMITTING THE STATEMENT OF DEFICIENCIES
DEFICIENCIES BEING ISSUED**

USE REGIONAL OFFICE LETTERHEAD STATIONERY

Name
Address
City State Zip Code

Re: Date of Survey
Reply Required by:

Dear Operator:

Enclosed is a copy of the statement of deficiencies resulting from the Article 36 survey of your agency by staff from our office. As Operator of the agency you are responsible for the agency's compliance with all applicable rules and regulations. A copy of this letter and the deficiency report are being forwarded to the agency administrator.

It is your responsibility to ensure that a detailed plan of correction is completed, including the person (by title) responsible for the plan and the completion date for correction of each deficiency. This plan of correction is to be provided on the statement of deficiencies sent to the administrator.

Your plan of correction will be reviewed by this office. When deemed acceptable, a follow-up visit will be made to determine whether the deficiencies have been corrected in accordance with the plan of correction. If your plan of correction is unacceptable, staff from our office will contact the agency administrator to discuss the items involved.

Your plan of correction must be returned to this office no later than ten (10) days after receipt of this letter. A copy should be retained for your records.

Please do not hesitate to contact this office if you have any questions concerning this matter.

Sincerely yours,

Name
Regional Administrator or Designee

cc: Agency Administrator

APPENDIX H

FORM LETTER: TRANSMITTING COMPLIANCE WITH THE REGULATIONS

USE REGIONAL OFFICE LETTERHEAD STATIONERY

Name of Operator
Street
City State Zip Code

Re: Date of Survey

Dear Operator:

The results of the Article 36 survey of your agency by staff from our office indicate that all standards are set forth in 700, 766, and 767 of 1L NYCRR were deemed to be in compliance. This is being sent to you in your capacity as Operator with ultimate responsibility for the agency. A copy of this letter is being forwarded to the agency administrator.

Please do not hesitate to contact this office if you have any questions about the survey visit.

Sincerely yours,

Name
Area Administrator or Designee

cc: Agency Administrator

APPENDIX I

FORM LETTER: TRANSMITTING ACCEPTABLE PLAN OF CORRECTION

USE AREA OFFICE LETTERHEAD STATIONERY

Name of Operator
Street
City State Zip Code

Re:
Date of Survey

Dear Operator:

Please be advised that the plan of correction relating to the recent Article 36 survey of your agency has been reviewed by this office. All items were found to be acceptable, and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies cited.

If you have any questions regarding this matter, please contact _____ at _____.

Sincerely,

Name
Regional Administrator or Designee

cc: Agency Administrator

Section .02 FORM LETTER: TRANSMITTING UNACCEPTABLE PLAN OF CORRECTION

USE AREA OFFICE LETTERHEAD STATIONERY

Name of Operator
Street
City State Zip Code

Re:
Date of Survey:
Reply Required By:

Dear Operator:

Your plan of correction dated _____, as submitted in response to our recent Article 36 survey, has been reviewed by the surveyors involved. The items found to be unacceptable are stated on the attached report.

It is requested that you submit an acceptable plan of correction for each of the deficiencies cited within ten (10) days of receipt of this letter.

If you have any questions regarding this matter, please contact _____ at _____.

Sincerely,

Name
Regional Administrator or Designee

cc: Agency Administrator

Appendices

APPENDIX K

Post Certification/Approval Revisit Report – DOH-1504

This Appendix is a Form
that is unavailable in electronic format.
It will be available to the successful bidder.

APPENDIX L

License Transaction Notice (BPMLTN)

This Appendix is a Form
that is unavailable in electronic format.
It will be available to the successful bidder.

APPENDIX M

**FORM LETTER: APPLICATION/PRE-SURVEY NEW SITE
USE OFFICE LETTERHEAD/STATIONERY**

Name of Operator
Street
City State Zip Code

Re: New Site
Agency Name
Agency Address
Reply Required by:

Dear Operator:

Prior to the approval and licensure of an additional site of service delivery, the staff of the _____ Area Office of the Office of Health Systems Management will conduct an initial survey.

To begin this approval process, please complete the enclosed licensed home care services agency (LHCSA) application (pages 2-6) with information pertinent to the new site you are requesting to open. Also complete the enclosed checklist and submit the pre-survey information and materials. If any of the requested pre-survey materials are identical to those submitted for an existing agency or to another Area Office, it is not necessary resubmit these materials for review. Please indicate on the attached checklist the location and date that these materials were submitted.

The requested information and materials should be submitted to the Area Office within 30 days of receipt of this letter. A date for the onsite portion of the survey will be scheduled with you following receipt and review of this material.

The new site may not become operational until the approval of this office is obtained.

If you have any questions about this process, please contact me at _____.

Sincerely,

Name
Area Administrator or Designee

cc: Agency Administrator

Appendices

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF HOME HEALTH CARE SERVICES
New Site (Pre-Survey Materials)

Agency Name _____ Agency Address _____

Provider Instructors: Complete the checklist and attach the requested pre-survey materials. If any of the requested materials have been previously submitted, list the specific Regional Office and date the materials were submitted, in the columns entitled Previously Submitted – Location and Date.

Item	Enclosed	Previously Submitted – Location and Date
Names and addresses of all offices (branch and principal Administrative)		
Name and title of person administratively responsible For Agency		
Name and license number of registered professional Nurse(s) responsible for direction and supervision of Patient care and health services		
Membership of quality assurance and any other Committee		
Contracts and/or other agreements		
Patients' rights		
Job description for each position		
Materials available to public about agency		
Clinical record forms		
Policies and procedures for:		
- personnel		
- patient's rights		
- patient services		
- admission, retention, and discharge of patients		
- clinical records		
- care of medical supplies, equipment and appliances		
- orientation of staff		
- supervision of home health aides and personal care aides		
- emergency/disaster preparedness plan		
- patient complaints/grievances		

I hereby certify that the _____
(address)
site will be under the administration of the same operator that has been approved by the Public Health Council to operate other sites of service in New York State.

I understand that misrepresentation or falsification of any information contained on or submitted with this form may be punishable by fine and/or imprisonment under New York State law.

APPENDIX O

PATIENT RECORD REVIEW FORM

Identification			
Start of Care? Payor Source			
Diagnosis			
RN Approval of Admission			
Receipt of Bill of Rights			
Informed of Service to be Provided			
Complaint/Grievance Procedure			
Informed of Financial Liability			
Advanced Directives			
Medical Orders (MD; DO; DPM; NP)			
Signed Within 30 days			
All dx, meds, Rx prognosis			
Renewed every 6 months			
Telephone orders signed			
Nursing Assessment			
Plan of Care including dx, px, Mental status, freq. Of service, meds, Rx, diet, functional medications, and rehab potential			
Therapy orders include specific procedures and modalities and amount of frequency and duration			
Renewed every six months			
Supervisory Reports			
Aide Activity Sheets			
Progress Notes			
Discharge Summary			
DC planning and MD Notification			
Documentation of contact with Family and informal support			
Assigned staff			

APPENDIX P

REVIEW OF PERSONNEL

AGENCY:

SURVEYOR:

1. Employee						
2. Title						
3. Date of Birth						
4. Date of Hire						
5. Qualifications Certificate/License						
6. Application: Signed and Dated						
7. Verified Reference Checks						
8. Health Status: Pre/Annual with Freedom of Habituation Statement						
9. Rubella: Titre/Immunization						
10. Rubeola: Titre/Immunization Born after 01/01/57						
11. Mantoux: (Annually)						
12. Personal ID						
13. Administrative/ Performance/Evaluation/Home Visit						
14. Orientation to Policy & Procedures/Specific Duties/ Emergency Disaster Plan						
15. Inservice: (HHA 12 hours/ PCA 6 hours)						
16. HIV Confidentiality (Annually)						
17. Universal Precautions (Annually)						
18. Resignation						
19. Criminal History Background Check						

Licensed Home Care Services Agencies
Surveillance Process