*Sample Action Plan Summary & Request for Plan of Correction*

APC.10 - Each patient will have an individualized plan of care. (G570) It includes the following: 1. All pertinent diagnoses; (G574) 2. All patient care orders, including verbal orders; (G576) 3. The patient's mental, psychosocial, and cognitive status; (G574) 4. The types of services, supplies, and equipment required; (G574) 5. The scope and frequency and duration of visits to be made; (G574) 6. The mode of care-delivery including the use of telecommunications when applicable; 7. Prognosis and rehabilitation potential; (G574) 8. Functional limitations; (G574) 9. Activities permitted; (G574) 10. Nutritional requirements; (G574) 11. All medications and treatments; (G574) 12. Food and drug allergies; 13. Safety measures to protect against injury; (G574) 14. A description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors; (G574) 15. Patient and caregiver education and training to facilitate timely discharge; (G574) 16. Patient-specific interventions and education; (G574) 17. Measurable outcomes anticipated from implementing and coordinating the plan of care with goals identified by the organization and the patient; (G574) 18. Information related to any advance directives; and (G574) 19. Any additional items the organization or physician or allowed practitioner may choose to include. (G574) It is required that each patient receive the home health services that are written in an individualized plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and identifies patient specific measurable outcomes and goals that the organization clinical staff anticipates will occur as a result of implementing and coordinating the plan of care.

## Sample Citation  Group 1: APC.10 – Individualized Plan of Care (Condition Level)

**CMS Tag:** G-570 / G-574 | **CMS CFR:** 484.60 & 484.60(a)(2)

Standard Requirement: Each patient must receive the home health services that are written in an individualized plan of care (POC), including any revisions or additions. The POC must specify the care and services necessary to meet patient-specific needs identified in the comprehensive assessment, identify responsible disciplines, and establish patient-specific measurable outcomes and goals.

**Specific Clinical Record Findings (APC.10):**

- CLINICAL RECORD 1: POCs xyz were missing required supplies for the IV infusion and IV PICC line, as well as hospital readmission risk factors/interventions.

- CLINICAL RECORD 2 & HOME VISIT 2: Patient observed with a suprapubic catheter. POCs xyz completely omitted catheter supplies, change frequency, size parameters, balloon fill volumes, and readmission risk evaluations.
- CLINICAL RECORD 3: POC xyz ordered bolus feedings ('100ml - TwoCal HN x 5 cartons per day') but omitted the administration route (gastrostomy tube) and flush specifications. Omitted tracheostomy size/ventilator settings for a ventilator-dependent patient. Missing respiratory/gastrostomy goals and readmission risk profiles.
- CLINICAL RECORD 4: POC xyz was missing descriptions of hospital readmission risk factors and corresponding risk-reduction interventions.
- CLINICAL RECORD 5: POC xyz listed Apixaban (a high-alert anticoagulant) 5 mg oral 1 tablet twice per day but completely omitted critical bleeding precautions and readmission risk factors.
- CLINICAL RECORDS xyz: All evaluated plans of care uniformly lacked documented assessments of individual emergency department visit/hospital readmission risks and mandatory underlying mitigation interventions.
- CLINICAL RECORD 16: POC xyz ordered concurrent anticoagulant therapies (Aspirin 81 mg daily and Warfarin Sodium 1 mg nightly) but omitted standard clinical bleeding precautions and readmission risk protocols.

**Required Agency guidance for Each Sample Citation :**

*1. Offer clinical guidance*

## Sample Citation  Group 2: APC.14 – Delivery of Written Patient Instructions

**CMS Tags:** G-614 (Visit Schedule), G-616 (Medications), G-618 (Treatments) | **CMS CFR:** 484.60(e)(1), 484.60(e)(2), 484.60(e)(3)

Standard Requirement: The organization must provide the patient and caregiver(s) with clear, written instructions outlining the visit schedule, complete medication instructions (names, dosages, frequencies, and administrator details), and specific treatments to be administered by agency staff or designees.

## Sample Citation  Group 3: APC.23 – Timeliness of Transfer and Discharge Summaries

**CMS Tags:** G-1022 | **CMS CFR:** 484.110(a)(6)(i) & 484.110(a)(6)(iii)

Standard Requirement: A discharge summary must be sent to the receiving primary care practitioner within 5 business days of discharge. Complete transfer summaries for unplanned hospitalizations must be sent within 2 business days of becoming aware.

## Sample Citation  Group 4: CDT.11 & CDT.12 – Home Health Aide Assignment & Tasks

**CMS Tags:** G-798, G-800 | **CMS CFR:** 484.80(g)(1) & 484.80(g)(2)

Standard Requirement: Home health aides must be explicitly assigned to specific patients by an RN, and written care instructions (Aide Care Plans) must be prepared before care begins. Aides must deliver services exactly as ordered and document them completely.

## Sample Citation  Group 5: CDT.14 & CDT.15 – Home Health Aide Supervision

- CDT.15 Timing Failures (G-808): Supervisory assessments must occur at least every 14 days.

## Sample Citation  Group 6: EP.6 – Patient Emergency Preparedness Plans

**CMS Tag:** E-17 | **CMS CFR:** 484.102(b)(1)

Standard Requirement: Documented individualized emergency preparedness (EP) plans matching community/geographic risks must be discussed with, provided to, and maintained for each patient as part of their comprehensive assessment.