SAMPLE NEW YORK STATE DEPARTMENT OF HEALTH LICENSED HOME CARE SERVICES AGENCY (LHCSA) Survey Documents/Information Required

Agency Name _____ **Survey Date(s)** _____

Please provide the following information in specified time frame: _____

Information/Documents	Time Frame	Received
1. Current Patient Census & Active Patient Roster including SOC date, primary diagnosis, services provided, payer source		
2. Patient visit schedule for survey dates-include date, service/discipline		
3. Personnel Roster-including employee name, title, date of hire		
4. List of discharged patients within the past 3 months with SOC date, discharge date, primary diagnosis		
5. Provide area/space for surveyors to work		
6. Name of Owner/Operator		
7. Name of agency responsible RN		
8. Organizational Chart		
9. Admission Packet including Bill of Rights		
10. Agency Policy & Procedure Manual including policies on: COVID-19 Policies including PPE Policy Emergency Disaster Preparedness Plan Clinical Supervision Criminal History Record Check Home Care Worker Registry Complaint Policy Influenza Vaccination/Flu Mask Requirement Health Commerce System New policies implemented since last survey		
11. Complaint/Grievance Log		
12. Emergency Preparedness Plan		
13. QI Committee Meeting minutes past 12 months		
14. Governing Authority Meeting Minutes past 12 months		
15. List of Contracts/Agreements related to patient care delivery		
16. Copy of DOH approved Management Agreement if applicable		
17. Orientation to clinical record & access to clinical records and the equipment necessary to read any clinical records maintained electronically. The agency must also produce a paper copy of the record, if requested by the surveyor.		
Other Focus Items		
Infection Control & Prevention Plan		
Staff EDP Call Down List		
Community Partner EDP Contact List		
Health Requirements & TB Risk Assessment		

NYS Department of Health
LHCSA PRE-SURVEY WORKSHEET
(*Updated June 2017*)

Agency Name: _____ **License #** _____

Address: _____

Phone Number: _____

Surveyor: _____ **Date:** _____

1.Review Regional Office Paper File:

Identify any correspondences/changes since last survey (operator, counties, services):
_____

Determine if agency has approved Management Contract in place. Yes ☐ NO ☐
If yes: Management entity name: _____ Effective Date: _____

2. Review ASPEN: *In Aspen look under "Services" and "Notes" sections.*

Identify services & Programs (HHATP, waiver, etc.) approved: _____

_____

_____

3. Type & Last Survey Date: _____

SOD issued: Yes ☐ No ☐ Acceptable POC: Yes ☐ NO ☐

Issues from POC to follow up: _____

4. ACTS- Review Complaints since last survey: # complaints: _____

- **Closed complaints** (Review allegations & findings)
  May use a closed complaint for Discharge Record Review.

Identify trends/issues: _____

- **Open complaints: (All open complaints should be investigated during the survey).**

Log # _____ **Log #**_____

- Allegations-
- patient/personnel names-
- patterns-

Additional notes: _____

5. Health Commerce System (HCS) - Initiate HCS Surveyor Worksheet
Review agency's communication directory for role assignments.

6. Home Care Registry (HCR) – Initiate HCR Surveyor Worksheet.
Print out and review agency profile - (This will also be used onsite).

7. Review Home Care Registry (HCR) to determine if agency operates a HHATP.
Does agency operate a HHATP? Yes ☐ No ☐
If yes, initiate HHATP Surveillance Tool.

8. Review CHRC Employee Negative Determination List (monthly report)
Initiate "CHRC Compliance Protocol and Surveyor Worksheet".

9. Determine compliance with submission of latest LHCSA Statistical Report
(send email with agency name and license # to hcstatrpts@health.ny.gov
Submitted? Yes ☐ NO ☐ (cite Tag-1454)

10.Determine compliance with participation in required DOH Emergency Drill
(send email with agency name and license # to hcemergency@health.ny.gov
Submitted? Yes ☐ NO ☐ (cite Tag-1454)

11. Analysis of information collected:

Patient record sample: *Sample may be based on LHCSA Questionnaire (if used), complaint issues/trends, new services, new counties, etc.*

Personnel record sample: *Sample may be based on LHCSA Questionnaire (if used). Review at least one record from each service offered and any personnel observed on home visits.*

Issues to address on survey/Notes:

_____

_____

_____

_____

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NYS Department of Health
LHCSA Entrance Conference Worksheet
(Updated July 2017)

AGENCY:_____ **License #** _____

Surveyor: _____ **Date:** _____

Requirement	**Surveyor Notes**	**Complete**
Present identification and introduce survey team		
Request meeting with appropriate staff (administrator, director, supervisor, agency responsible RN)		
Explain purpose of survey		
Explain survey process (how many surveyors, time onsite, record reviews, home visits, extent agency staff may be involved)		
Obtain information on agency operation		
Verify: Agency Legal structure/ownership- individual, partnership, for profit, not for profit,		
Agency Organization- relationship to any corporate structure		
Identify: President/Chairman of Board, Administrator		
Does agency have a DOH approved Management Agreement? If yes, request copy of management agreement.		
Identify: HPN Coordinator Administrator/DPS/DON/RN Emergency Response Coordinator CHRC Authorized Person(s) HCR Updater and Viewer (s)		
Identify any changes since last survey- *ownership, services, geographic are, etc*		
Services provided:		
Services provided indirectly (by contract):		
Determine overlap and agency contracts with: *ALPs, Managed Care Plans, CHHA, LTHHCP, LDSS/HRA for Home Attendant/Personal Care Program, Private Duty Nursing, NHTD or TBI waiver programs, etc.*		
Do they operate a HHATP? HHATP Coordinator:		
Do they have an Infusion Company? If yes, request P & P.		
Do they conduct Flu immunization clinics? If yes, request P & P.		
Address issues from Pre-Survey Prep: _____		
Identify patient record documentation system- paper/electronic and request surveyor access to records.		
Names of key staff*: Supervisors, quality improvement*		
Identify agency point person (primary resource responding to the surveyor's questions)		
Request area/space to work		
Provide "LHCSA Survey Documents/Information Required" to administrator/designee		

NYS Department of Health
LHCSA Survey Documents/Information Required
Agency Copy

Agency _____ **Date:** _____

Please provide the following information to Surveyors:

Information/Document
Current Patient Census & Active Patient roster including start of care (SOC) date, primary diagnosis, services provided, payer source.
Patient visit schedule for survey dates- include date, service/discipline
Personnel Roster - including employee name, title, date of hire
List of discharged patients within past 3 months with SOC date, discharge date, primary diagnosis
Provide area/space for surveyors to work
Name of Owner/Operator
Name of agency responsible RN
Organizational Chart
Admission Packet including Bill of Rights
Agency Policy & Procedure Manual including polices on: Clinical Supervision Criminal History Record Check Home Care Worker Registry Complaint Policy Influenza Vaccination/Flu Mask Requirement Health Commerce System *New policies implemented since last survey
Complaint/Grievance Log
Emergency Preparedness Plan
QI Committee Meeting minutes past 12 months
Governing Authority Meeting Minutes past 12 months
List of Contracts/Agreements related to patient care delivery
Copy of DOH approved Management Agreement if applicable.
Orientation to clinical record & access to clinical records and the equipment necessary to read any clinical records maintained electronically. The agency must also produce a paper copy of the record, if requested by the surveyor. Assign staff member to assist the team with review of electronic records.

NYS Department of Health
LHCSA Survey Documents/Information Required
DOH Surveyor Copy

Agency _____ **Survey Date:** _____

Surveyor Name: _____

Information/Document	**Date/Time Provided**	**Initials**
Current Patient Census & Active Patient roster including start of care (SOC) date, primary diagnosis, services provided, payer source.		
Patient visit schedule for survey dates- include date, service/discipline		
Personnel Roster - including employee name, title, date of hire		
List of discharged patients within past 3 months with SOC date, discharge date, primary diagnosis		
Provide area/space for surveyors to work		
Name of Owner/Operator		
Name of agency responsible RN		
Organizational Chart		
Admission Packet including Bill of Rights		
Agency Policy & Procedure Manual including polices on: Clinical Supervision Criminal History Record Check Home Care Registry Complaint Policy Influenza Vaccination/Flu Mask Requirement Health Commerce System *New policies implemented since last survey		
Complaint/Grievance Log		
Emergency Preparedness Plan		
QI Committee Meeting minutes past 12 months		
Governing Authority Meeting Minutes past 12 months		
List of Contracts/Agreements related to patient care delivery		
Copy of DOH approved Management Agreement if applicable.		
Orientation to clinical record & access to clinical records and the equipment necessary to read any clinical records maintained electronically. The agency must also produce a paper copy of the record, if requested by the surveyor. Assign staff member to assist the team with review of electronic records.		

NYS Department of Health
Health Commerce System (HCS) Surveyor Worksheet
(Updated June 2017)

Agency: _____ Survey Date: _____

Surveyor: _____ Date HCS reviewed presurvey: _____

Agency has HCS Account: Yes ☐ No ☐

Roles assigned, accurate and current for:
Note during pre-survey if the agency's roles are assigned on the HCS Communication Directory and verify info for accuracy during onsite survey.

24/7 Facility Contact: Yes ☐ No ☐

Administrator/DPS: Yes ☐ No ☐

Emergency Response Coordinator: Yes ☐ No ☐

HPN Coordinator: Yes ☐ No ☐

CHRC AP: Yes ☐ No ☐ N/A ☐ *(if aides not employed by agency)*

Home Care Registry Agency Updater: Yes ☐ No ☐ N/A ☐ *(if aides not employed by agency)*

Home Care Registry Agency Viewer: Yes ☐ No ☐ N/A ☐ *(if aides not employed by agency)*

Observe HCS coordinator successfully access HCS: Yes ☐ No ☐

HCS Policy is reviewed at least annually: Yes ☐ No ☐

Policy addresses the following:

(a) agency has sufficient, knowledgeable staff available and maintains and keep current accounts: Yes ☐ No ☐

(b) agency's HCS coverage consistent with hours or operation: Yes ☐ No ☐

(c) sufficient designation of the agency's HCS coordinator(s) to allow for HCS individual user application: Yes ☐ No ☐

(d) designation by the agency operator of sufficient staff users of the HCS accounts to ensure rapid response to requests for information by the State and/or local Department of Health: Yes ☐ No ☐

(e) adherence to the requirements of the HCS contract: Yes☐ No ☐

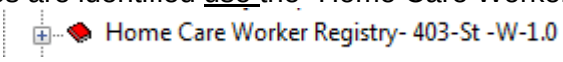
(f) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, reviewed on a monthly basis: Yes ☐ No ☐

NYS Department of Health
Home Care Registry (HCR) Worksheet
Distributed June 2017

Agency: _____ **Date:** _____/_____/_____

Surveyor: _____

Purpose: To determine agency compliance with Home Care Registry (HCR) regulations (10 NYCRR Part 403) requiring all Licensed Home Care Services Agencies (LHCSAs) and Certified Home Health Agencies (CHHAs) who employ aides to enter Home Health Aides (HHAs) and Personal Care Aides (PCAs) into or update information, in the registry within 10 business days after hiring, name change, or termination of an employee.

Note: If deficiencies are identified use the "Home Care Worker Registry" regulation set and tags found in ASPEN. 

Pre-Survey Preparation:

1. **Obtain Agency Profile report from the Health Commerce System** –
   This report lists Active and Inactive Aides with date of birth, date of hire and date of separation. The Agency Profile report will be used for review onsite. To access the report:

   - Access Health Commerce System (HCS).
   - Click on MY CONTENT.
   - Click on ALL APPLICATIONS.
   - Scroll down to Home Care Registry.
   - Click on the GREEN PLUS SIGN.
   - Green Plus Sign will become RED minus sign.
   - Return to HOME, HCR will now be under MY APPLICATIONS and you can access it from
   - your home page.
   - Click on HOME CARE REGISTRY.
   - Click on SEARCH FOR HOME CARE AGENCY.
   - Enter agency name and license #, then Search.
   - Verify the correct agency and click on PRINT AGENCY PROFILE.

2. **Verify in the HCS, that the agency's communication directory has the Home Care Agency Registry Updater & Home Care Agency Registry Viewer roles assigned on HCS.**

NYS Department of Health
Home Care Registry (HCR) Worksheet
Distributed June 2017

Agency: _____ **Date:** _____/_____/_____

Surveyor: _____

On-site Survey:

1. **Request and review agency's Home Care Registry policy and procedure. Does the policy/procedure (P&P) contain the following elements:**

   - Does the P&P reference one or more Home Care Agency Registry Updater to enter/update information in HCR? Yes ☐ No ☐
   - Does the P&P reference obtaining the potential HHA's or PCA's training certificate issued by the state-approved training program? Yes ☐ No ☐
   - Does the P&P reference checking HCR to determine if a potential employee has completed state approved education or training on or after September 25, 2009? Yes ☐ No ☐
   - Does the P&P reference entering the required employee information within 10 business days of being employed or hire start date into HCR? Yes ☐ No ☐
   - Does the P&P reference updating, adding, or correcting the HCR upon receiving information from the employee that the registry is incorrect within 10 business days? Yes ☐ No ☐
   - Does the P&P reference updating the registry within 10 business days of the employee's termination date? Yes ☐ No ☐
   - Does the P&P reference providing access to employee's HCR information and the employee's right to a printed report if requested? Yes ☐ No ☐

2. **Verify agency's HCS HCR Viewer and Updater staff assigned. Are the names the same as those listed on HCS Communication Directory?**

3. **Request agency's employee roster that includes, date of hire (start date) and job title.**

   - Compare the employee roster to the Agency Profile. Are there any HHA or PCA names on the roster that do not appear on the profile? Yes ☐ No ☐
     (Note: use date registry was printed.) Negative findings:
     _____
     _____
   - Was employee data entered into registry within 10 business days of date of hire/start date? Yes ☐ No ☐
     (Note: use date registry was printed.) Negative findings:_____
     _____

NYS Department of Health
Home Care Registry (HCR) Worksheet
Distributed June 2017

Agency: _____ **Date:** _____/_____/_____
Surveyor: _____

- Are there any HHA or PCA names listed on the agency profile which are not on the employee roster? Yes ☐ No ☐ Negative findings: _____
  _____
- Interview Human Resource (HR) Manager or Administrator and request termination dates of employees listed on profile that are not on roster.
- Are any names on profile report that were terminated greater than 10 business days? Yes ☐ No ☐ Note: use date registry was printed.) Negative findings:
  _____
  _____
- Are there any names listed on the registry which the HR manager/Administrator state were changed (i.e. recently married, divorced, etc.)? Yes ☐ No ☐
  Negative findings: _____
  _____
- Interview the HR manager/Administrator and request the dates the manager was informed of the name change. Are the name changes within 10 business days of the printing of the profile? Yes ☐ No ☐ Negative findings: _____

_____

Notes:

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Criminal History Record Check Home Care Surveillance Protocol

Division of Home and Community Based Services
10-27-2016 Revised and updated 5/3/18

Purpose: Validate home care agency's compliance with Criminal History Record Check (CHRC) regulations found in 10 NYCRR Part 402 and Department directives during re-licensure survey using the CHRC Surveyor Checklist.

Survey objectives to determine if the agency is:

- submitting CHRC requests on all subject individuals within the required time frame;
- using the required DOH process and the required DOH forms for obtaining and requesting CHRCs;
- supervising temporary employees while awaiting the CHRC determination;
- acting on non-favorable determination letters (Hold in Abeyance, Pending Denials, Final Denials) and immediately removing temporary employees from providing patient care;
- submitting the DOH termination notice when required; and
- maintaining confidentiality of CHRC information.

Document all findings on the CHRC Surveyor Worksheet.

Offsite Pre-survey Activities:

1. Identify CHRC Authorized Person(s) (CHRC APs) listed on the Health Commerce System and notate on CHRC Surveyor Worksheet. The agency is required to designate at least two CHRC APs.

2. Review agency's past survey compliance related to CHRC requirements.

3. Obtain Monthly CHRC Negative Determination Report and select survey sample of at least 2 employees listed on the report, notate on CHRC Surveyor Worksheet.

This report includes the following:

Hold in Abeyance: Letter is issued to the employee and the agency and indicates the individual has open charges that will result in a CHRC denial if there is a conviction. The individual must be immediately removed from providing direct care. The individual is responsible for contacting CHRC when the charges are resolved, at which time CHRC legal will revisit the case and make a determination. If the provider no longer plans to employ this individual, an electronic termination must be submitted to the DOH.

Pending Denial: Letter is issued to the employee and the agency and indicates the individual has criminal convictions sufficient for CHRC to deny employment eligibility. The individual must be immediately removed from providing direct care. The individual has thirty days to submit rehabilitation information to assist CHRC in making a final determination.

Final Denial: Letter is issued to the employee and the agency and indicates the individual must be immediately removed from providing direct care. An electronic

termination must be submitted to the DOH. This letter may be issued after a Pending Denial letter when the employee has not provided sufficient evidence of rehabilitation.

Onsite Activities:

1. Verify agency's CHRC AP(s) are accurate and currently employed.

2. Request a current employee roster (which includes all employed licensed and non-licensed staff), date of hire, and title. Verify the number of currently employed aides/non-licensed staff subject to CHRC.

3. Review the agency's CHRC policies and procedures and determine if it meets requirements. The policy must address the following elements:

    - Designation of at least two CHRC Authorized Person(s) (APs);
    - Determination of who is subject to a CHRC (aides and non-licensed employees);
    - Employee rights including informed consent for CHRC and use of required DOH consent form, right to withdraw application, and challenge of determination;
    - Process for requesting CHRC within 15 calendar days of date of hire;
    - Process for obtaining Livescan fingerprinting using required DOH process/forms;
    - Supervision of temporary personnel while awaiting determination;
    - Procedures for Hold-in- Abeyance, Pending Denial, or Final Determination letters;
    - Process for reporting terminations and separations to the Department including use of required DOH form;
    - Retention, confidentiality, of CHRC records.

4. Determine and verify that the agency has implemented and is following their CHRC policies and procedures based on information gathered during the survey.

5. Conduct interviews with the agency's CHRC AP or administrative staff to ascertain:

    - The agency's procedure when they receive a Negative Determination letter- Hold in Abeyance, Pending Denial, or Final Denial.
    - The agency's procedure for supervision of temporary staff while awaiting CHRC determination.

6. Select a sample of current employed aides/non-licensed personnel (a minimum of 6 personnel records and generally no more than 15 personnel records) should be reviewed to determine compliance with CHRC requirements. The sample should be selected using the agency's employee roster and at least 2 employees listed on the Monthly CHRC Negative Determination Report.

    ***Please note that the survey sample may be expanded at the discretion of the survey team if there are issues identified or dependent on the number of aides employed by the agency.**

7. Review each personnel record to determine documentation of the following:

   - CHRC **Acknowledgement and Consent Form** (102) was completed and signed by the prospective employee.

   - CHRC **Request for Criminal History Record Check Form** (103) electronic submission was submitted within 15 days of date of hire. This can be verified by print out of the Form 103, or receipt of CHRC determination letter, or LiveScan Request letter date, or listing on the agency's CHRC Roster.

   - Required <u>weekly</u> supervision was conducted during temporary employment while awaiting CHRC determination. The agency is required to provide **onsite direct observation and evaluation** of the temporary employee for the **first week of supervision and every other week.** This onsite supervision must be done by an individual employed by the agency with at least 1-year experience working in an Article 36 agency (this may be a licensed health care professional, senior aide or other paraprofessional). In the alternating weeks, the supervision may be on-site *or* by phone call to the patient or patient's representative.

     Documentation must include the dates of supervision, the name(s) of person conducting the supervision, and type of supervision (onsite or by phone call).

   - CHRC Determination Letter is in file.

   - Evidence that negative CHRC determination letters (Hold-in-Abeyance, Pending Denial, or Final Denial) were acted upon and that the employee was removed from providing direct care "immediately" upon notice consistent with the CHRC letter date. (if applicable)

   - Documentation that CHRC electronic termination form (105) was submitted if applicable. The termination form is required and must be submitted: within 30 days of the Final Denial letter date; and/or within 30 days of date of termination, <u>or</u> within 30 days of being permanently removed from direct care even if the person is still employed by the agency in a different capacity.

   - Verify CHRC information is maintained and retained confidentially and not available beyond the Authorized Persons, agency representatives, or Human Resource Department involved in hiring decisions. In addition, the Charge/Conviction Report and Evidence of Rehabilitation attachments to the letters must be secured separately and accessible only to CHRC AP(s), Agency Representative(s) and those involved with hiring decisions.

8. Determine the agency's compliance with the requirement to notify DOH using Termination Form 105 within 30 days of employee's termination/separate date. Select at least 2 separated aides from the either the Agency Profile of Inactive Aides listing or from the agency's list of terminated aides and review each personnel record to verify that Termination Form 105 was submitted within 30 days of the aide's separation date.

CHRC Surveyor Worksheet
Division of Home and Community Based Services
10 NYCRR Part 402
Updated May 2018

Agency Name:	**Surveyor Name(s):**	**Survey Dates:**

Review Agency's CHRC Policy. Does Agency have a CHRC Policy? Yes □ No □

Policy Name/Policy Date:

Does policy address the following elements:
Designation of at least two CHRC Authorized Person(s) (APs) Yes □ No □
Determination of who is subject to a CHRC Yes □ No □
Employee rights, informed consent, use of required DOH consent form, right to withdraw application, and challenge of determination Yes □ No
Process for requesting CHRC within 15 calendar days of date of hire Yes □ No □
Process for obtaining Livescan fingerprinting within 15 calendar days of date of hire using required DOH forms Yes □ No □
Supervision of temporary personnel while awaiting determination Yes □ No □
Procedures for Hold-in- Abeyance, Pending Denial, or Final Determination letters Yes □ No □
Process for reporting terminations and separations to the Department including use of required DOH form Yes □ No □
Retention, confidentiality of CHRC records. Yes □ No □

Notes regarding policy review and whether agency is following their written procedures:

CHRC Authorized Person (AP)

Are at least 2 CHRC APs assigned? Yes □ No □ CHRC APs are accurate/currently employed? Yes □ No □ If AP is missing/no longer employed or other, please describe:	Names of CHRC AP(s): _____ _____ _____ _____

Interview Notes:

Personnel Record Review (review a minimum of 6 records)					
Employee Name/Date of Hire	**Consent Form (102) on file?**	**CHRC request within 15 days?**	**Weekly Supervision documented?**	**Determination Letter/Date**	**Confidentiality maintained?**

Personnel Record Review of employees with Negative Determination Letter (at least 2 records)			
Employee Name/ Date of Hire	**Negative Determination Letter Date**	**Immediately removed from direct care?**	**Termination form (105) submitted within 30 calendar days of Final Denial Date /Termination date/permanent removal from direct care?**
		Yes□/No□ Date:	Yes□/No□ Date:
		Yes□/No□ Date:	Yes□/No□ Date:
		Yes□/No□ Date:	Yes□/No□ Date:
		Yes□/No□ Date:	Yes□/No□ Date:

Personnel Record Review of separated/terminated employees (Select 2 employees from inactive aide list or agency list of terminated aides)	
Employees Name/Date of Separation	**Termination form (105-e) submitted within 30 calendar days of termination/separation?**
	Yes□/No□ Date:
	Yes□/No□ Date:

NOTES:

NYS Department of Health
Observation Home Visit (HV) Surveyor Worksheet
(Created: June 2017)

Agency: _____**HV Date:** ___/___/_____

Employee/Title: _____**Surveyor:** _____

Patient: _____

The purpose of the home visit is to assess the agency's compliance with regulations pertaining to patient rights, accepted professional standards of practice, supervision of care, assessment of patients, plan of care, clinical records; observe care provided; and interview patient.

Observations	Yes	No	N/A	Comments
Employee wearing ID badge?				
Greeted/Identified client?				
Communicated purpose of visit?				
Follows agency's bag technique/infection control policies?				
Gathered supplies/equipment?				
Care provided consistent with care plan/orders?				
Procedure(s) followed per agency policy(ies)?				
Universal Precautions/protective equipment utilized effectively?				
During declared flu season was employee wearing mask if not vaccinated for influenza?				
Privacy maintained?				
Communicates effectively with patient/family?				
Washed/cleansed hands before re-entering bag?				
Cleansed equipment before replacing in bag?				
Contacted MD/Nurse (if applicable)?				
Documented visit?				
Patient Interview				
Did patient receive admission packet/patient rights?				
Is patient getting services at frequency ordered?				
Is patient satisfied with agency services/care?				
If not satisfied, does he/she know the agency complaint process and DOH complaint hotline# ?				

Other Notes: _____

_____

NYS Department of Health
LHCSA CLINICAL RECORD REVIEW FORM (Updated June 2017)

Agency: _____ **Date:** _____/_____/_____

Surveyor: _____

Patient's Name/Patient #	
DOB	
Start of Care (SOC)	
Primary Diagnosis	
Secondary Diagnoses	
Patient rights – written/verbal evidence of being informed of services.	
Informed of financial liability	
Receipt of Complaint Grievance Procedure	
Medical Orders (MD, DO, DPM, NP)	
Orders include: all Dx., Meds, Treatments, prognosis, services and freq, other pertinent info related to agency POC	
Orders signed within 12 months	
Renewed every 6 months	
Telephone orders signed 12 months	
Therapy Orders: Amount or Frequency, duration, specific procedures and modalities	
Initial RN assessment – prior to agency admission and dev of POC incl PNA and Flu assessment	
RN assessment at least every 6 mo.	
Plan of Care (POC) includes: pertinent Dx. prognosis, mental status, freq of services, Meds, Txs, diet, functional limitations, rehab potential.	
POC: Discipline(s) Ordered- SN PT OT SLP MSW Aide Frequency of Services	
POC is reviewed/revised as frequently as necessary to reflect changing care needs, but not less than every 6 months.	
RN reports changes in patient condition to the MD.	
Clinical Supervision Initial placement of aide and oriented to patient. Aide has appropriate documented experience.	

Staff assigned per training, orientation, or demonstrated skills	
Supervisory visit when there is a change in patient condition.	
Aide Care Plan complete-Includes tasks and freq., instructions of aide observations that should be reported to the supervisor, reviewed or updated at least every 6 months or with change in patient care needs.	
Aide Activity Sheets: Type/Times/Frequency and documentation of care provided as specified in the Aide Care Plan	
Progress Notes: Signed and dated following each home visit or phone contact by professionals providing care.	
Discharge Summary- when D/C from agency	
D/C Planning and **MD Notification** at least 48 hours prior to D/C.	

Notes:

NYS Department of Health
PERSONNEL RECORD REVIEW FORM (Updated June 2017)

AGENCY: _____ **Date:** _____

Surveyor: _____

Please Note: Documentation is acceptable as an original, fax or copy of original.

Employee Name		
Title/Discipline		
Date of Birth		
Date of Hire		
Personal ID verified (I 9 Form)		
Qualifications- verification of Certificate/License/Registration		
Application - Signed and Dated		
Verified Reference Check- previous employers if applicable (minimum 2)		
Performance Evaluation & Home Visit annually		
Orientation to Policy & Procedures, Specific Duties, Universal Precautions/HIV, Emergency Plan		
HIV Confidentiality (Annually)		
Universal Precautions (Annually)		
Emergency Response Plan (orientation & annually)		
In-service (HHA 12 Hours/PCA 6 Hours) annually		
Criminal History Background Check – (Aides employed after 4/05)		
Pre-Employment Physical by MD, PA or RN with special training in primary care - with Freedom of Habituation Statement- (within 12 months of date of hire)		
Annual Health Assessment		
Rubella - Titre/Immunization		
Measles - Titre/Immunization if born after 01/01/57		
Results of Tuberculin Skin Test or FDA Blood Assay (Pre-Employ & Annual)		
Influenza Vaccine (Annually)		

NYS Department of Health
LHCSA Governing Authority (766.9) Surveyor Worksheet
(Created June 2017)

Agency: _____ **Date:** _____/_____/_____

Surveyor: _____

Governing Authority (GA):

1. Are there meeting minutes for the GA? Yes ☐ No ☐

2. Does the GA meet once a year (minimum)? Yes ☐ No ☐ Dates: _____

3. Does the GA adopt new and approve revisions/amendments to written policies? Yes ☐ No ☐
   Notes: _____

4. Are there sufficient staff to provide care/services to accepted patients? Yes ☐ No ☐
   Notes: _____

5. Does the GA employ at least one licensed/currently registered nurse to direct and supervise patient /health care services/activities? Yes ☐ No ☐ Notes: _____

6. If agency has approved Management Agreement, is the GA present and does the GA retain full legal authority over agency operations? Yes ☐ No ☐ N/A ☐ Notes: _____

Complaint Requirements:

7. Is there a complaint policy/procedure that includes:
   (a) Documentation of the complaint receipt, investigation and resolution and maintenance of a complaint log? Yes ☐ No ☐ Notes: _____

   (b) A review of each complaint with a written response to all written complaints and to oral complaints if requested by individual making the oral complaint? Yes ☐ No ☐ Notes: _____
   _____

   (c) Explaining the complaint investigation findings/decisions within 15 days of receipt of complaint? Yes ☐ No ☐ Notes: _____

   (d) Advising the complainant of the right to appeal and the appeal procedure? Yes ☐ No ☐
   Notes: _____

   (e) An appeals process with review by GA within 30 days of receipt of the appeal? Yes ☐ No ☐
   Notes: _____

   (f) Patient notification of the NYS DOH complaint telephone number? Yes ☐ No ☐
   Notes: _____

8. Is there a complaint Log? Yes ☐ No ☐ Notes: _____

9. Does the complaint log show evidence of complaint receipt date, investigation, and resolution?
   Yes ☐ No ☐ Notes: _____
   _____

NEW YORK STATE DEPARTMENT OF HEALTH
LHCSA Contract Surveyor Tool
Revised July 2017

DO NOT REVIEW CONTRACTS WITH: Managed Care Organizations (MCO), Veterans Administration (VA)

Instructions: If the contract meets the requirement: surveyor should indicate in the box: "MET" and initial. If the contract does not meet the requirement: surveyor should indicate in the box "NOT MET" and initial and provide additional comments if needed.

Contract Entity Name				
Written Contract				
Services Provided				
Supervision/Evaluation Of Services				
Charges/Financial Arrangement				
Indemnification Provisions				
Signed by both Parties				
Currently In Effect				
Termination Clause				
Personnel 766.11 Requirement Clause				

NEW YORK STATE DEPARTMENT OF HEALTH
LHCSA Contract Surveyor Tool
Revised July 2017

DO NOT REVIEW CONTRACTS WITH: Managed Care Organizations (MCO), Veterans Administration (VA)

Instructions: If the contract meets the requirement: surveyor should indicate in the box: "MET" and initial. If the contract does not meet the requirement: surveyor should indicate in the box "NOT MET" and initial and provide additional comments if needed.

Notwithstanding Clause 766.10(d)				

NYS Department of Health
LHCSA Quality Assurance Surveillance Tool - 766.9 (k)
Updated June 2017

Agency: _____ Survey Date: _____

Surveyor Name: _____ Staff name interviewed: _____

Compliance is determined based on review of agency's QA Plan, QI committee minutes, and staff interview.

1. Is there evidence of an agency Quality Assessment/Quality Improvement (QA/QI) Program? Yes ☐ No ☐ Notes: _____
   _____
2. Is there a Quality improvement (QI) committee responsible for establishing and overseeing standards of care? Yes ☐ No ☐ Notes: _____
   _____
3. Does QI committee consist of consumer and health care professionals? Yes ☐ No ☐ Notes:
   _____
   _____
4. Does QI committee meet 4 times a year? Yes ☐ No ☐ Notes: _____
   Dates of the meetings: _____
5. Is there a sign in attendance document for each meeting? Yes ☐ No ☐ Notes: _____
   _____
6. Is a consumer present at each meeting? Yes ☐ No ☐ If consumer not present at each meeting, document dates not present. Notes: _____
   _____
7. Are there meeting minutes for each QI meeting? Yes ☐ No ☐ Notes: _____
   _____
8. Does QI committee review policies and procedures and recommend changes to governing authority? Yes ☐ No ☐ Notes: _____
   _____
9. Does QI committee conduct clinical record reviews for the review of the safety, adequacy, type and quality of services provided? Yes ☐ No ☐ Notes: _____
   _____
10. Did clinical record reviews include random selections of active patients and patients discharged within past 3 months? Yes ☐ No ☐ Notes: _____
    _____
11. Were record reviews conducted for all cases of identified patient complaints? Yes ☐ No ☐
    Notes: _____
12. Did QI committee prepare and submit a written summary of review findings to governing authority? Yes ☐ No ☐ Notes: _____
    _____

NYS Department of Health
LHCSA Quality Assurance Surveillance Tool - 766.9 (k)
Updated May 2017

Agency: _____ Survey Date: _____

Surveyor Name: _____ Staff name interviewed: _____

13. If the agency sponsors a HHATP (activate HHATP Surveillance Tool) – Is there evidence that the LHCSA is conducting quality monitoring of the HHATP? Look for: effectiveness of the instructors, lesson plans, materials/equipment utilized, evaluation of the SPT, student evaluation of the program and analysis of an annual evaluation of testing results, admission standards and program completion rates. N/A ☐ Yes ☐ No ☐ Notes: _____
_____

14. Is there evidence that the HHATP quality monitoring resulted in developing and implementing strategies for improvement of the HHATP? N/A ☐ Yes ☐ No ☐ Notes: _____
_____

15. Is there evidence of an HHATP annual evaluation report submitted to the sponsoring LHCSA's Governing authority? N/A ☐ Yes ☐ No ☐ Notes: _____
_____

Notes:

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NYS DEPARTMENT OF HEALTH
Influenza Vaccination / Flu Mask Requirement Surveyor Worksheet
(Updated June 2017)

Agency: _____ Survey Date: _____

Surveyor: _____

1. Does the agency have a policy regarding Influenza vaccination and the Flu mask requirement? Yes ☐ No ☐ Notes: _____
   _____

   Does the policy (10 NYCRR Section 2.59):

2. Identify which staff the regulation applies to, where and when masks must be worn? Yes ☐ No ☐ Notes: _____
   _____

3. Address the use of masks for unvaccinated staff during flu season as determined by the Commissioner? Yes ☐ No ☐ Notes: _____
   _____

4. Document the manner/frequency staff are to be educated regarding regulation requirements and the use of masks? Yes ☐ No ☐ Notes: _____
   _____

5. Document the manner in which the agency will monitor for compliance of the regulation? Yes ☐ No ☐ Notes: _____
   _____

6. Does the agency have a roster of all staff not vaccinated? Yes ☐ No☐
   If not, interview the administrator - How does the agency keep track of those who have not been vaccinated? Notes: _____
   _____

7. During home visit(s), were staff vaccinated, and if not, were staff compliant with Flu mask requirement if influenza is prevalent as determined by the Commissioner? Yes ☐ No ☐ N/A ☐ Notes: _____
   _____

Notes:_____
_____
_____
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_____
_____

NYS Department of Health
LHCSA Emergency Preparedness Surveyor Worksheet
(Revised 1-30-18)
766.9 (c) and DAL DHCBS 16-11 issued December 1, 2016

Agency: _____ **Survey Date:** ___/___/_____

Surveyor: _____

Emergency Response Plan must have evidence of:

1. Identification of types of potential emergencies? Yes ☐ No ☐

2. Agency is required to maintain current patient roster that contains:
- patient name, address and telephone number? Yes ☐ No ☐
- emergency contact numbers of family, caregiver(s) and/or healthcare proxy? Yes ☐ No ☐
- Patient Classification Level? Yes ☐ No ☐
- Transportation Assistance Level (TAL)? Yes ☐ No ☐
- ventilator dependency? Yes ☐ No ☐
- identification of patients dependent on use of electricity for health care needs? Yes ☐ No ☐
- other specific patient information critical to first responders? Yes ☐ No ☐

3. Call down list of agency staff with telephone numbers? Yes ☐ No ☐

4. Procedure for alternate communication if telephone/computer become disabled? Yes ☐ No ☐

5. Contact list of community partners that includes at a minimum: local health dept., local emergency management, Emergency Medical Services and law enforcement? Yes ☐ No ☐

6. Procedure for responding to requests for information by community partners in an emergency? Yes ☐ No ☐

7. Evidence of agency participation in drill/exercise annually? Yes ☐ No ☐

8. Annual review (and as needed) of plan? Yes ☐ No ☐ Date of last review: _____

Policies and Procedures Addressing:

9. .How patient roster will be kept current? Yes ☐ No ☐

10. How the staff call-down list will be kept current? Yes ☐ No ☐

11. How the community partners contact list will be kept current? Yes ☐ No ☐

12. Orientation/yearly in-service of staff to their responsibilities in emergency plan? Yes ☐ No ☐

13. Did agency participate in most recent required DOH Emergency Response Drill/Survey? Yes ☐ No ☐

Notes: _____

_____

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

August 12, 2019
OHIM DAL 19-01

Dear Administrator / Technology Officer:

The New York State Department of Health (Department) is implementing a new notification protocol that providers should use to inform the Department when they have experienced a potential cyber security incident at their facility or agency. The attached document provides the contact information for each DOH Regional Office and is in effect immediately upon your receipt of this letter. This document should also be posted as signage throughout your facility or agency locations for immediate awareness and reference by your staff.

We recognize that providers must contact various other agencies in this type of event, such as local law enforcement. The Department, in collaboration with partner agencies, has been able to provide significant assistance to providers in recent cyber security events. Our timely awareness of this type of event enhances our ability to help mitigate the impact of the event and protect our healthcare system and the public health. The Department has designed a more efficient process to engage assistance for providers, as needed. Therefore, this protocol should be immediately implemented by all providers of the following types:

- Hospitals, nursing homes, and Diagnostic and Treatment Centers
- Adult care facilities
- Home Health Agencies, Hospices, Licensed Home Care Services Agencies (LHCSA)

Providers should ensure they make any other notifications regarding emergency events that are already required under statute or regulation. For example, a cyber security event should be reported to the New York Patient Occurrence Reporting and Tracking System (NYPORTS), under Detail Code 932.

Thank you for your attention to this important activity. Please submit any questions you may have by email to: ohim@health.ny.gov

Sincerely,

Mahesh Nattanmai
Chief Health Information Officer
Office of Health Information Management

Attachment: Cybersecurity_ReportingGuide_poster.pdf

You're the Key to Reporting a Cybersecurity Incident!

A cybersecurity incident is the attempted or successful unauthorized access, use, disclosure, modification, or destruction of data or interference with an information system operations.

Business Hours

8:30 am to 4:45 pm weekdays and non-holidays, unless noted

Capital District — (518) 402-1036
Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington

Central New York — (315) 477-8400
Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga and Tompkins

Metropolitan Area — (212) 417-5550
9:00 am to 5:00 pm
Bronx, Kings, New York, Queens and Richmond

Central Islip — (631) 851-8050
9:00 am to 5:00 pm
Nassau and Suffolk

New Rochelle — (914) 654-7005
9:00 am to 5:00 pm
Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester

Western Area — (716) 847-4505
Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Orleans, Ontario, Schuyler, Seneca, Steuben, Wayne, Wyoming and Yates

After Hours Emergencies

4:45 pm to 8:30 am weekdays. Available 24 hours a day on weekends and holidays.

NYSDOH Duty Officer — (866) 881-2809
Select option #1 for reporting an emergency.

CALL 911 if there is immediate threat to public health or safety.

In all cases, the cybersecurity incident should be reported to law enforcement.

NEW YORK STATE | Department of Health