

Part 420, Subpart C of this chapter. The HHA also must disclose the following information to the State survey agency at the time of the HHA's initial request for certification, for each survey, and at the time of any change in ownership or management:

(1) The name and address of all persons with an ownership or control interest in the HHA as defined in §§ 420.201, 420.202, and 420.206 of this chapter.

(2) The name and address of each person who is an officer, a director, an agent or a managing employee of the HHA as defined in §§ 420.201, 420.202, and 420.206 of this chapter.

(3) The name and address of the corporation, association, or other company that is responsible for the management of the HHA, and the name and address of the chief executive officer and the chairman of the board of directors of that corporation, association, or other company responsible for the management of the HHA.

(c) *Standard: Compliance with accepted professional standards and principles.* The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.

§ 484.14 Condition of participation: Organization, services, and administration.

Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Administrative and supervisory functions are not delegated to another agency or organization and all services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency. If an agency has subunits, appropriate administrative records are maintained for each subunit.

(a) *Standard: Services furnished.* Part-time or intermittent skilled nursing services and at least one other therapeutic service (physical, speech, or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as a pa-

tient's home. An HHA must provide at least one of the qualifying services directly through agency employees, but may provide the second qualifying service and additional services under arrangements with another agency or organization.

(b) *Standard: Governing body.* A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. The governing body appoints a qualified administrator, arranges for professional advice as required under § 484.16, adopts and periodically reviews written bylaws or an acceptable equivalent, and oversees the management and fiscal affairs of the agency.

(c) *Standard: Administrator.* The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff; employs qualified personnel and ensures adequate staff education and evaluations; ensures the accuracy of public information materials and activities; and implements an effective budgeting and accounting system. A qualified person is authorized in writing to act in the absence of the administrator.

(d) *Standard: Supervising physician or registered nurse.* The skilled nursing and other therapeutic services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse). This person, or similarly qualified alternate, is available at all times during operating hours and participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.

(e) *Standard: Personnel policies.* Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current.

(f) *Standard: Personnel under hourly or per visit contracts.* If personnel under hourly or per visit contracts are used

by the HHA, there is a written contract between those personnel and the agency that specifies the following:

(1) Patients are accepted for care only by the primary HHA.

(2) The services to be furnished.

(3) The necessity to conform to all applicable agency policies, including personnel qualifications.

(4) The responsibility for participating in developing plans of care.

(5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA.

(6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation.

(7) The procedures for payment for services furnished under the contract.

(g) *Standard: Coordination of patient services.* All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. A written summary report for each patient is sent to the attending physician at least every 60 days.

(h) *Standard: Services under arrangements.* Services furnished under arrangements are subject to a written contract conforming with the requirements specified in paragraph (f) of this section and with the requirements of section 1861(w) of the Act (42 U.S.C. 1495x(w)).

(i) *Standard: Institutional planning.* The HHA, under the direction of the governing body, prepares an overall plan and a budget that includes an annual operating budget and capital expenditure plan.

(1) *Annual operating budget.* There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense.

(2) *Capital expenditure plan.* (i) There is a capital expenditure plan for at

least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than \$600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds \$600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds.

(ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health and Crippled Children's Services) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following:

(A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

(B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations.

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(C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency.

(3) *Preparation of plan and budget.* The overall plan and budget is prepared under the direction of the governing body of the HHA by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA.

(4) *Annual review of plan and budget.* The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA.

(j) *Standard: Laboratory services.* (1) If the HHA engages in laboratory testing outside of the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the FDA, such testing must be in compliance with all applicable requirements of part 493 of this chapter.

(2) If the HHA chooses to refer specimens for laboratory testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter.

[54 FR 33367, August 14, 1989, as amended at 56 FR 32973, July 18, 1991; 56 FR 51334, Oct. 11, 1991; 57 FR 7136, Feb. 28, 1992; 66 FR 32778, June 18, 2001]

§ 484.16 Condition of participation: Group of professional personnel.

A group of professional personnel, which includes at least one physician and one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.

(a) *Standard: Advisory and evaluation function.* The group of professional per-

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sonnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program. The meetings are documented by dated minutes.

[54 FR 33367, August 14, 1989, as amended at 56 FR 32974, July 18, 1991]

§ 484.18 Condition of participation: Acceptance of patients, plan of care, and medical supervision.

Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

(a) *Standard: Plan of care.* The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel participate in developing the plan of care.

(b) *Standard: Periodic review of plan of care.* The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in