(ii) Document both the existence of the complaint and the resolution of the complaint; and

(iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated.

(2) Any HHA staff (whether employed directly or under arrangements) in the normal course of providing services to patients, who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the HHA and other appropriate authorities in accordance with state law.

(f) *Standard: Accessibility*. Information must be provided to patients in plain language and in a manner that is accessible and timely to—

(1) Persons with disabilities, including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

(2) Persons with limited English proficiency through the provision of language services at no cost to the individual, including oral interpretation and written translations.

[82 FR 4578, Jan. 13, 2017, as amended at 84 FR 51825, Sept. 30, 2019; 85 FR 27628, May 8, 2020; 86 FR 62421, Nov. 9, 2021]

§ 484.55 Condition of participation: Comprehensive assessment of patients.

Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment.

(a) *Standard: Initial assessment visit*. (1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner-ordered start of care date.

(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician or allowed practitioner who is responsible for the home health plan of care, the initial assessment visit may be made by the appropriate rehabilitation skilled professional. For Medicare patients, an occupational therapist may complete the initial assessment when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech-language pathology or physical therapy) that establishes program eligibility.

(b) *Standard: Completion of the comprehensive assessment*. (1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.

(2) Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.

(3) When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician or allowed practitioner, a physical therapist, speech-language pathologist, or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. For Medicare patients, the occupational therapist may complete the comprehensive assessment when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech-language pathology or physical therapy) that establishes program eligibility.

(c) *Standard: Content of the comprehensive assessment.* The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:

(1) The patient's current health, psychosocial, functional, and cognitive status;

(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;

(3) The patient's continuing need for home care;

(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs;

(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

(6) The patient's primary caregiver(s), if any, and other available supports, including their:

(i) Willingness and ability to provide care, and

(ii) Availability and schedules;

(7) The patient's representative (if any);

(8) Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary. The OASIS data items determined by the Secretary must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.

(d) *Standard: Update of the comprehensive assessment.* The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than—

(1) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a—

(i) Beneficiary elected transfer;

(ii) Significant change in condition; or

(iii) Discharge and return to the same HHA during the 60-day episode.

(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner-ordered resumption date;

(3) At discharge.

[82 FR 4578, Jan. 13, 2017, as amended at 85 FR 27628, May 8, 2020; 86 FR 62421, Nov. 9, 2021]

§ 484.58 Condition of participation: Discharge planning.

(a) *Standard: Discharge planning.* An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

(b) *Standard: Discharge or transfer summary content.* (1) The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.

(2) The HHA must comply with requests for additional clinical information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner.

[84 FR 51883, Sept. 30, 2019]