

FREE AGENCY RESOURCE



15 Survey-Risk Warning Signs

A practical self-assessment for home health and hospice clinical leaders

HOW TO USE THIS CHECKLIST

Review a representative sample of active and recently discharged records. For each warning sign, mark Yes when the risk is present, Partial when the process is inconsistent, or No when evidence supports a reliable process. Assign an owner and deadline for every priority item.

1**Physician orders are missing, late, unsigned, or inconsistent**

Sample active charts for orders that do not match the current plan of care, frequency, medication profile, or treatment actually provided.

☐ YES ☐ PARTIAL ☐ NO

2**The medication profile does not tell one reliable story**

Look for duplicates, omitted route or frequency, missing PRN parameters, discontinued medications that remain active, and differences between the home supply and agency record.

☐ YES ☐ PARTIAL ☐ NO

3**Medication reconciliation is treated as a one-time admission task**

Confirm that hospitalization, physician visits, new prescriptions, caregiver reports, and recertification trigger a documented reconciliation and escalation process.

☐ YES ☐ PARTIAL ☐ NO

4**Plans of care contain generic or outdated interventions**

Review whether diagnoses, goals, interventions, frequency, caregiver ability, risk factors, and measurable progress reflect the patient's current condition.

☐ YES ☐ PARTIAL ☐ NO

Clinical records and care coordination

Trace each concern from identification through action and follow-up.

5

Visit notes do not support the ordered skilled need

Check whether documentation explains assessment, skilled intervention, teaching, response, progress, and why continued skilled care remains reasonable and necessary.

☐ YES ☐ PARTIAL ☐ NO

6

Wound documentation varies between clinicians

Verify location, measurements, tissue characteristics, drainage, surrounding skin, treatment performed, tolerance, physician notification, and plan consistency.

☐ YES ☐ PARTIAL ☐ NO

7

Changes in condition are reported but not closed out

Trace abnormal findings from discovery through physician notification, new instructions, implementation, patient or caregiver education, and follow-up.

☐ YES ☐ PARTIAL ☐ NO

8

Recertification decisions are made without organized evidence

Confirm that continued need, progress, barriers, goals, utilization, orders, and physician certification requirements are reviewed before the deadline.

☐ YES ☐ PARTIAL ☐ NO

9

Discharge planning begins too late

Look for early documentation of expected outcomes, barriers, caregiver readiness, community resources, and communication with the patient and physician.

☐ YES ☐ PARTIAL ☐ NO

Operations, accountability, and improvement

Confirm that agency systems create evidence of reliable practice.

10

Missed visits lack a consistent escalation pathway

Review attempts to contact the patient, reason for the missed visit, physician notification when required, risk assessment, rescheduling, and discharge considerations.

☐ YES ☐ PARTIAL ☐ NO

11

IDG or case-conference actions disappear after the meeting

Confirm that decisions are assigned to a responsible person, tracked to completion, and documented in the appropriate agency record.

☐ YES ☐ PARTIAL ☐ NO

12

Facility communication is informal or incomplete

Check whether changes, concerns, treatments, and follow-up are communicated through a repeatable process without relying only on texts or verbal messages.

☐ YES ☐ PARTIAL ☐ NO

13

Staff education occurs without competency or follow-up evidence

Determine whether education addresses the identified problem and whether leadership verifies that practice actually changed afterward.

☐ YES ☐ PARTIAL ☐ NO

14

Audits count errors but do not identify patterns

Aggregate findings by clinician, process, location, diagnosis, and recurrence so leadership can correct the workflow behind repeated deficiencies.

☐ YES ☐ PARTIAL ☐ NO

15

Corrective actions have no effectiveness monitoring

Every major correction should identify an owner, deadline, audit method, sample, frequency, success threshold, reporting path, and response when the threshold is missed.

☐ YES ☐ PARTIAL ☐ NO

TURN FINDINGS INTO ACTION

Your 30-day corrective priority sheet

Choose the three highest-risk issues. Focus first on concerns affecting patient safety, current compliance exposure, repeated failures, and time-sensitive survey or certification requirements.

PRIORITY	OWNER	CORRECTIVE ACTION	DUE	HOW EFFECTIVENESS WILL BE CHECKED
1				
2				
3				

QUICK TRIAGE

0-2 risks present

Continue routine monitoring and validate that controls remain effective.

3-5 risks present

Create a focused improvement plan with leadership review and a defined re-audit date.

6+ risks present

Consider an organized readiness assessment and immediate risk-prioritized corrective plan.

Need an independent review?

Reyes Consultants provides RN-led survey readiness, clinical documentation audits, Plan of Correction support, IDG and clinical operations guidance, and Fractional DPCS consulting. Schedule a confidential agency fit call at www.reyesconsultants.com.

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