Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	747977	07/17/2025
Name of Provider or Supplier	**Street Address, City, State**	
Quality First Home Health Care Inc	2503 N Us Highway 281, Ste 100, Marble Falls, TX	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
G0000	A recertification survey was conducted on 7/15/2025. The census was: 110 L&CHHS: 110 Abbreviations/Acronyms: L&CHHS: Licensed and Certified Home Health Services OASIS: Outcome and Assessment Information Set RN: Registered Nurse
G0536	A review of all current medications CFR(s): 484.55(c)(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. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to review medications the patient is currently using and failed to include a list of medications in the patients clinical record in 2 out of 3 patient records reviewed (Client 1 and Client 2). This failure could place the agency's patients at risk for medication mismanagement,

as agency personnel was unable to monitor for possible side effects, compliance with regimen, or need for medication adjustment.

Record review of the document titled Home Health Certification and Plan of Care for Patient 1, signed and dated 6/26/25, revealed the patients Plan of Care for the Certification Period of 5/31/25 to 7/29/25. Under the subtitle Medications, it was written NONE, as in the patient had no medications. Under the list of diagnoses, the patient was listed as having Type 2 Diabetes Mellitus (blood sugar disorder), osteomyelitis (infection of bone), Chronic Kidney Disease (kidney disorder), End Stage Renal Disease (severe kidney disorder), Dependence on Renal Dialysis (needs kidney treatments weekly), Type 2 Diabetes with Diabetic Polyneuropathy (damage of nerves), Hyperlipidemia (high fat in blood), Anemia (low red blood cells in blood), and Gastrointestinal Hemorrhage (bleed of the stomach or intestines). Further review of this document revealed a statement under the heading Goals/Rehabilitation Potential /Discharge Plans that read Patient will demonstrate compliance with medications as prescribed. Patient/caregiver will verbalize/demonstrate understanding of medication schedule, purpose, side effects and any special precautions related to medication regimen by 7/25/25. Further review of this document revealed a statement under the heading Orders of Discipline and Treatments that read, Skilled nurse to review medication profile and reconcile medications as needed. Skilled nurse may instruct and reinforce medication teaching related to the use of medications to treat disease processes. Skilled nurse may fill medi-planner per current medication orders/profile every visit.

In an interview with Patient 1s family member, FM 1 on, 7/22/25 at 8:30 AM, FM 1 confirmed that Patient 1 was on multiple medications while receiving services from the agency. She estimated Patient 1 was on over 20 medications at the time.

Review of the document titled Visit Note Report, for the visit dated 5/31/25, there was a note, signed by RN C, that stated, Patient was unable to provide medications for review during the SOC [Start of Care] visit as they were located upstairs in the bedroom. Patient was unable to access the medications due to mobility limitations (uses wheelchair) and no one else was home to retrieve them. This prevented proper medication reconciliation and review during the initial assessment.

Record review of the document titled Home Health Certification and Plan of Care for Patient 2, signed and dated 7/9/25, revealed the patients Plan of Care for the Certification Period of 6/11/25 to 8/9/25. Under the subtitle Medications, it was written NONE, as in the patients had no medications. Under the list of diagnoses, the patient is listed as having Acute Kidney Failure (kidney disorder), Type 2 Diabetes Mellitus (blood sugar disorder), Hypertensive Chronic Kidney Disease (kidney disorder), Morbid obesity (severe obesity), hyperlipidemia (fat in the blood), osteoarthritis (painful joints/bones), iron deficiency anemia (low iron in blood), and a presence of a coronary graft (artificial tubing that helps to open artery to increase blood flow in a damaged artery). Further review of this document revealed a statement under the heading Goals/Rehabilitation Potential/Discharge Plans that read Patient will demonstrate compliance with medications as prescribed. Patient/caregiver will verbalize/demonstrate understanding of medication schedule, purpose, side effects and any special precautions related to medication regimen by end of episode. Further review of this document revealed a statement under the heading Orders of Discipline and Treatments that read, Skilled nurse to review medication profile and reconcile medications as needed. Skilled nurse may instruct and reinforce medication

teaching related to the use of medications to treat disease processes. Skilled nurse may fill medi-planner per current medication orders/profile every visit.

In an interview with Patient 2s family member, FM 1 on, 7/22/25 at 9:49 AM, FM 2 confirmed that Patient 2 was on multiple medications while receiving services from the agency.

In an interview with the Alternate Administrator on 7/16/25 at 3:55 PM, the Surveyor asked why no medications were listed on the Plan of Care for either Patient 1 or Patient 2. After taking some time to review the records and make a phone call, the Alternate Administrator confirmed that Patient 1 and Patient 2 should have medications listed. The Alternate Administrator stated that with the severe list of diagnosis that both patients had, there was no way they were on no medications. He could not locate the list of medications for either patient in the Electronic Medical Record, and eventually stated that the reasons we cant see it in the Electronic Medical Record for those patients is because it is not there.

In an interview with the Alternate Administrator on 7/17/25 at 9:35 AM, he stated that overnight their OASIS reviewers pulled charts and did not locate any other patients with missing medication lists. He stated that they believe these 2 missing medications lists were the result of human error, and that it got missed by multiple people. He stated that the nurse performing the initial assessment must not have performed a medication reconciliation. He stated that once the nurse submits a Plan of Care, the Plan of Care is then reviewed by the OASIS compliance team before being submitted, and that this was missed on that side too. He stated that all clinicians who saw the patients in the meantime should have caught it when doing the med reconciliation, but that it appears no one did.

In a phone interview on 7/17/25 at 11:20 AM with RN C, who performed the initial Comprehensive Assessment on Patient 2, she stated that she did have digital photo of Patient 2s medications at discharge from the hospital, but that she must not have uploaded it. The Surveyor asked if a medication reconciliation was performed. RN C stated that they discussed the patients pain medications because she was in a lot of pain and not taking all of her prescribed medications.

In a phone interview on 7/17/25 at 11:30 AM with RN A, who did later subsequent visits with Patient 1, she stated that she did not think she performed a medication reconciliation during these visits. She stated his medications were kept upstairs and all visits were conducted downstairs, so she did not look at his medications. She stated she was unsure if they discussed his medication, but that she did not recall him letting her know of any changes to his medications.

In a phone interview on 7/17/24 at 11:58 AM with RN B, who performed the initial Comprehensive Assessment on Patient 1, she stated that the patient was alone in the house in a wheelchair, and when he tried to perform the medication reconciliation, the patient stated that all his medications were upstairs and that he would not let the nurse go get them. She stated that she was unable to review the patients medication that day, but that she put this in her note. The Surveyor asked her if she notified the nurse who would be continuing the patients care that the patients medications had not been reviewed or listed in the Patients Electronic Medical Record. She stated that she documented she was unable to review the medication, and she told the patient to bring it up with the next nurse.

In an interview with the Administrator on 7/17/25 at 12:05 PM, the Administrator stated that during the initial assessment all clinicians should have performed a medication reconciliation with patients to ensure the agency has an up-to-date list of medications that the patient is currently taking. She stated that these were inputted to the patients Plan of Care, which then went to the OASIS review team. The OASIS Review team acted as a quality assurance team and reviewed the documents for errors or missing information before submission. She stated that clinicians are instructed to review medications with patients every visit. They are instructed to pull the medication list up in the Electronic Health Record, and review with the patient to ensure no changes have been made since the last time the medications were reviewed. The Surveyor asked what a nurse should do if for some reason they were unable to perform a medication reconciliation with the patient. The Administrator stated that in that case they instructed nurses to contact the provider for an updated medication list. She stated they could also contact the patients family members for assistance. She stated that not having a list of medications in the electronic health record could affect patient care because the nurse would be unable to perform effective medication management if they do not know what the patient is on. She stated that medications are something they should be looking at every visit to coordinate care. She stated it is a simple standard practice to do a medication reconciliation for every patient and to have an updated medication list in the electronic health record.

In a phone interview with the leader of the OASIS review team, Review Leader, on 7 /17/25 at 12:25 PM, Review Leader stated that their team is kind of seen like a Quality Assurance group. Review Leader stated that we take a chart and should scrub it from A to Z, offer any suggestions, see what is missing, and then submit the OASIS changes for the clinician to change if needed. Or in cases like this we would call the clinician and have them do the medication reconciliation since we would not be able to do that. Review Leader stated that they review every single Plan of Care that the agency completed. He stated that his team was aware of the missing information for Patient 1 and that they had tried to correct it but there was a miscommunication, and they did not get a response before it got locked. He stated that the other one [Patient 2] unfortunately fell through the checks that we had.

Review of the agencys policy titled Medication List and Monitoring, last updated 05 /02/24, read in part, An Agency registered nurse (RN) or other clinician qualified to perform comprehensive assessments (physical therapist (PT), occupational therapist (OT), speech-language pathologist (SLP) will be responsible for coordinating the efforts of monitoring the medication regimen by compiling assessment data through a collaborative effort of all Agency staff involved in the patients/clients care. A medication profile/list will be maintained on all patients/clients. Further review of the policy revealed a statement that read, The Agency will maintain a current, accurate list of all prescription and over-the-counter (OTC) medications taken by the patient /client (see the Medication Profile form). Oxygen therapy, including liters per minute, route, and frequency, will be documented on the medication profile. Professional clinical staff will update the medication list with any changes in the medication regimen.