Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	747977	06/11/2026
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)
E0000	A recertification survey was conducted on 6/9/26. The census was: L&CHH: 24 Abbreviations/Acronyms: L&CHH: Licensed Home Health
G0000	A recertification survey was conducted on 6/9/26. The census was: L&CHH: 24

	Abbreviations/Acronyms: L&CHH: Licensed Home Health
G0716	Preparing clinical notes CFR(s): 484.75(b)(6) Preparing clinical notes; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure skilled professionals maintained responsibility to prepare clinical notes in that the agency did not enforce a written policy for implementation of care for required documentation on missed visits or services for 1 of 7 patients when PTA 1 missed the scheduled visit on 6/9/26 and failed to complete documentation and reason for the missed visit. This failure could place patients at risk for decline in current health status or increased needs from the home health agency. Review of agencys Administrative Policy Manual, section 40 Implementing Care and Treatment revealed when the provision of care and treatment cannot be implemented as established on the care planning document (s), the patients/clients physician or allowed practitioner will be notified. If the Agency misses visits or services as required by the Plan of Care, it must notify the physician responsible or allowed practitioner of the missed visit if there is any potential for clinical impact upon the patient/client. The physician or allowed practitioner will decide whether the patient /client visit may be skipped, or additional intervention is required by the Agency due to the impact on the patient/client. The appropriate documentation will be completed and submitted by the discipline or the Nursing Supervisor. Per record review of patient 5s chart revealed SOC date of 3/8/2026. Patient 5 DOB 8.27.1955 diagnosis: Radiculopathy, Hypertension, Heart Failure, Obesity, Depression, Insomnia, Spinal Stenosis, GERD, Hyperlipidemia, Arthrodesis Status, Bypass Graft, Chronic Pain Syndrome. Review of the Plan of Care for Recertification Period 5/7/26-7/5/26, revealed patients received skilled nursing and physical therapy

services. Patient visits notes revealed missed visit dates included 5/23/26, 5/28/26, and 6/9/26. Patient records coordination care notes revealed missed visit coordination note dated 5/23/26 and 5/28/26 patient unable to receive services due to a doctors appointment. Coordination notes were reviewed for other missed visits on 6/9/26, services scheduled were physical therapy, however, no documentation with PTA 1 for this missed visit upon record review.

Interview with the Administrator on 6/10/26 at 9:20 AM in reference to missed visit documentation on patient #5 for physical therapy agency staff. Administrator reviewed patient records and stated she was unable to locate at this time but will review other areas of patient record due to some notes are faxed or emailed to patients. Administrator stated she will update surveyor once she reviews records in depth.

Follow up interview with Branch Director and Administrator on 6/11/26 at 10:40 AM about review of patient records for missed documentation, which Administrator stated she could not locate any documentation for missed visit on 6/9/26 with physical therapist. Asked Administrator who was assigned for the visit on 6/9/26, which she stated was PTA 1. Asked Administrator if the documentation included why the scheduled visit was missing, she stated there was no documentation in the patient record for the reason of the missed visit that she was able to find. Asked agency staff if there were monitoring within patient records when there were any missed visits, Branch Director stated she does run a weekly report where she spot checks missed visits. She stated this does not include all missed visits; however, it does include all disciplines offered by the agency. Asked Branch Director why it is important to have all patient records reflect services missed/received. Branch Director responded that the patient has the right to know when the agency staff are coming and physician plan of care must be followed because it is the patients rights.