Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	747990	10/13/2023
Name of Provider or Supplier	**Street Address, City, State**	
Jj Home Health Services, Inc	346 Oaks Trl Ste 200, Garland, 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 entrance conference was conducted on 10/10/2023. Licensed & Certified Home Health Services census was 1 patient. The Agency was in compliance with 42 CFR Part 484.102, Emergency Preparedness Requirements for Home Health Agencies.
G0000	A recertification survey entrance conference was conducted on 10/10/2023. The census was 1 licensed and certified patient. Acronyms used: SN- Skilled nurse

	POC- Plan of Care SOC- Start of Care PAS- Personal Assistance Services Pt.- Patient Hrs- hours PHC- Primary Home Care
G0608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure coordination of services between the Agency and all providers involved in the care for 2 (Patients #2 and 3) of 7 patients who received care and services from other providers.

This failure meant the agency failed to share information regarding the ongoing care and interventions with PAS agencies.

Patient #2: Discharged record review revealed a POC dated 10/30/2021-12/28/2021 with a SOC date 10/30/2021.

The POC included in the Psychosocial and Cognitive Status section, “… Pt. is living alone, has a paid primary care giver 30 hrs/week….”

An undated, unsigned, agency form titled, “Coordination of Care” included the following information about the PHC agency: name; phone number and contact person.

The form did not include the care and services provided by the agency or an agency contact person for coordination with services. The form was not signed by an agency employee and was not sent to the PHC agency.

Review of the entire client’s record revealed no documented coordination of care with the patient’s PHC provider.

Patient #3: Discharged record review revealed a POC dated 05/17/2023-07/15/2023 with a SOC date 01/17/2023.

The POC included in the Psychosocial and Cognitive Status section, “… daughter is primary care giver through PHC program for 23 hrs per week…. ”

An undated, agency form titled, “Coordination of Care” included the following information about the PHC agency: name; phone number and contact person.

The form did not include the care and services provided by the agency or an agency contact person for coordination with services. The form was not signed by an agency

	employee and was not sent to the PHC agency. Review of the entire client’s record revealed no documented coordination of care with the patient’s PHC provider. In an interview with the Administrator on 10/13/2023 at 12:15 PM, the surveyor reviewed the survey findings and asked why the agency did not coordinate care with Patient’s #2 and #3 PAS agencies. The Administrator stated the agency usually does coordinate with PAS agencies, but he did not see on the (Coordination of care) forms where the coordination was completed. The Administrator stated he was aware the coordination needed to include informing the PAS agencies of the care and services the patient’s received through his skilled care agency.
G0614	Visit schedule CFR(s): 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is not met as evidenced by: Based on observation, record review and interviews, the agency failed to provide the patient and caregiver with written information outlining a visit schedule including frequency of visits by home health staff in 1 (Patients #1) of 1 patients' home folders reviewed during home visits. This failure potentially placed the patients at risk of missed visits by staff when visits were not scheduled and conflicted with other appointments and the availability of the patients. FINDINGS: Patient #1: Review of the record revealed a POC dated 06/05/2023-08/03/2023 with a SOC date 06/05/2023. The POC listed the diagnoses: Hypertension (high blood pressure), Type 2 Diabetes (a chronic condition that affects the way the body processes blood sugar) and Osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time). The POC listed orders for SN visits once a week for nine weeks. Review of the record revealed no evidence that a visit schedule

	had been provided to Patient #1. During a home visit with Patient #1 on 10/13/2023 at 9:30 AM, the patient's home folder was reviewed. The patient expressed she did not speak English and pointed to her caregiver during the home visit interview. The surveyor asked Patient #1 and her caregiver if any paperwork from the home folder had been removed or placed elsewhere. The caregiver stated “No, it’s all there.” The surveyor asked if a written visit schedule to show when the SN would be visiting was provided to the patient. The caregiver stated, “no, but the nurse comes every Monday and usually calls the day before.” The home folder did not include a visit schedule for the patient. In an interview with the Administrator on 10/13/2023 at 12:00 PM, the surveyor reviewed the findings and asked why the patient did not have a written visit schedule provided by the agency. The Administrator stated, “it was overlooked or misplaced, we forgot it. It has been a practice in the past, they (nurses) were doing it (providing schedules) before.”