Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	747977	06/08/2023
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	Purpose of Visit: Recertification Survey Entrance Conference: 06/06/2023 at 11:11 a.m. with the Administrator/Alternate Director of Nursing. Agency Census: Licensed and Certified (L&C)-0 Exit Conference: 06/08/2023 at 4:36 p.m. with the Administrator/Alternate Director of Nursing and the Regional Director of Operations. The preliminary findings were discussed, and written instructions were provided for submitting a plan of correction within ten days of the receipt of the Statement of Licensure Violations. Abbreviations: BBP-Bloodborne Pathogens OSHA-Occupational Safety and Health Administration LVN-Licensed Vocational Nurse

	DON -Director of Nursing CFR -Code of Federal Regulations HHA-Home Health Agency SOC-Start of Care POC-Plan of Care