Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	757287	01/08/2026
Name of Provider or Supplier	**Street Address, City, State**	
Summa Home Health Care, Inc.	2500 E Foothill Blvd Unit 417, Pasadena, CA	

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)
G0610	Patients receive education and training CFR(s): 484.60(d)(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge. This ELEMENT is not met as evidenced by: Based on interview and record review, the Home Health Agency (HHA, an organization that delivers skilled nursing and other therapeutics service to a patient at home) failed to provide documented evidence that the patients and their primary caregivers received education and training to achieve their established goals as indicated in the individualized plan of care (POC) for two out of five sampled patients (Patient 4 and Patient 5) when: a. The HHA failed to provide documented evidence that education regarding fall prevention was given to Patient 4, Patient 5 and their caregiver after an incident of fall was reported. This failure had the potential for Patient 4 and Patient 5s fall recurrence and may result in serious injury and re-hospitalization. b. For Patient 4, the HHA failed to provide documented evidence that education regarding diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control) management was given to Patient 4 and caregiver after an incident of fall occurred. This failure had the potential for Patient 4s health condition to deteriorate requiring more care, medication and services and/or re-hospitalization. Findings:

a.1. During a review of Patient 4s Face Sheet (the front page of the chart summarizing basic patient information), undated. The Face Sheet indicated Patient 4s Start of Care (SOC) date was 1/1/2025, with diagnoses of diabetes mellitus, Heart failure (a heart disorder which causes the heart to not pump the blood efficiently) and cerebral infarction (stroke, loss of blood flow to a part of the brain).

During a review of Patient 4s POC for the certification period of 10/28/2025 to 12/26 /2025. The POC indicated Patient 4s established goal includes Patient/caregiver will remove all clutter from patients path, such as clothes, books, shoes, electrical chords, and other items, that may cause patient to trip by the end of episode

During a concurrent interview and record review on 1/7/2026 at 1:13 pm., with the Director of Patient Care Services (DPCS). Patient 4s [Licensed Vocational Nurse] (LVN) Skilled Nursing Visit, dated 12/5/2026 was reviewed. The LVN Skilled Nursing Visit indicated Patient had an unwitnessed fall during the week. The DPCS stated the note did not indicate any interventions during the visit after the reported fall. The DPCS stated there was nothing for HHA and nurses to do as the incident had already happened.

During an interview on 1/7/2026 at 1:48 pm., with the DPCS. The DPCS stated the visiting licensed nurses should be providing education and training regarding fall preventions; the nurses should reinforce teaching for fall safety, safe environment and for patients to ask for assistance when ambulating. The DPCS stated that one of the roles of the HHA and the nurses was to educate patients and caregivers, because the healthcare team are not present in their homes all the time. The DPCS stated not providing education and training to patients and caregivers may lead to their lack of knowledge on how to prevent falls, which would risk the patient for serious injury and possible re-hospitalization.

a.2. During a review of Patient 5s Face Sheet, undated. The Face Sheet indicated Patient 5s Start of Care (SOC) date was 7/3/2025, with diagnoses including but not limited to hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), heart failure, cerebrovascular attack (CVA-stroke, loss of blood flow to a part of the brain), seizure (sudden surge of electrical activity in your brain that causes sudden changes in awareness and muscle control) and anxiety (a mental condition characterized by is a feeling of fear, dread, and uneasiness).

During a review of Patient 5s POC for the certification period 10/31/2025 to 12/29 /2025. The POC indicated [Skilled nurses] teaching on fall prevention measures and Patient 5 had established goals of patient/caregiver will remove all clutter from patients path, such as clothes, books, shoes, electrical cords, and other items that may cause patient to trip by end of the episode.

During a concurrent interview and record review on 1/7/2026 at 1:40 pm., with the DPCS. Patient 5s LVN Skilled Nursing Visit, dated 12/11/2025. The LVN Skilled Nursing Visit indicated caregiver reported Patient 5 had a fall on 12/8/2025 and was taken to a hospital emergency room. Patient 5 was discharged the same day. The DPCS stated the visit note did not indicate any interventions to Patient 5 because the fall incident already occurred and the patient had gone to the hospital and came back with no serious injury.

During an interview on 1/7/2026 at 1:48 pm., with the DPCS. The DPCS stated the

visiting licensed nurses should be providing education and training regarding fall preventions; the nurses should reinforce teaching for fall safety, safe environment and for patients to ask for assistance when ambulating. The DPCS stated that one of the roles of the HHA and the nurses is to educate patients and caregivers, because the healthcare team are not present in their homes all the time. The DPCS stated not providing education and training to patients and caregivers may lead to their lack of knowledge on how to prevent falls, which would risk the patient for serious injury and possible re-hospitalization.

b. During a review of Patient 4s Face Sheet, undated. The Face Sheet indicated Patient 4s Start of Care (SOC) date was 1/1/2025, with diagnoses of diabetes mellitus, Heart failure (a heart disorder which causes the heart to not pump the blood efficiently) and cerebral infarction (stroke, loss of blood flow to a part of the brain).

During a review of Patient 4s POC for the certification period of 10/28/2025 to 12/26 /2025. The POC indicated Patient 4 is current medications include, but not limited to Insulin Glargine (long-acting insulin that regulates the blood sugar that works slowly over approximately 24 hours) 35 units (standard measurement of quantity) subcutaneous (injection given under the skin) every day and Insulin Lispro (fast-acting insulin to manage blood sugar) 10 units subcutaneous three times a day. The POC indicated the following goal Patient will be free from signs and symptoms of [hypoglycemia] (low blood sugar in the body) /hyperglycemia (high blood sugar in the body)

During a concurrent interview and record review on 1/7/2026 at 1:15 pm., with the Director of Patient Care Services (DPCS). Patient 4s LVN - Skilled Nursing Visit, dated 12/5/2025,12/14/2025, 12/27/2025 was reviewed. The DPCS stated there was no documented evidence that the nurse provided education or training to Patient 4 and the caregiver in relation to achieving this goal. The DPCS stated education regarding diabetes management should include how to appropriately use glucometer (a device that measures the sugar level in the blood), symptoms of having hypoglycemia or hyperglycemia and administering insulin injections. The DPCS stated educating the patient and the caregiver will prevent Patient 4s DM worsening and health deterioration that may require hospitalization.

During a review of HHAs policies and procedures (P&P), titled Patient Education Process, undated. The P&P indicated, but not limited to, the following:

- The scope of teaching will be determined by assessing the needsas well as by the plan of care, goals and established outcomes.

- [Education] will focus on increasing patient and family/caregiver potential to follow the plan of care and to meet established goals and maintaining the patients health status

- The clinician will assess, plan, implement, and evaluate the following on each patient and family/caregiver, as appropriateprescribed treatments, basic home safety, environmental and mobility safety

- Documentation of patient and family/caregiver education will consist of: describing what was taught to the patientdescribing the patients response to teaching, including

	the level of understanding and the ability to repeat or demonstrate what was taught and describing teaching planned for subsequent visit - The patients and family/caregivers knowledge, skills, and behaviors will be assessed during home visits through an interactive process. Reinforcement of instruction will be provided as needed