

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

January 9, 2026

VIA HAND DELIVERY AND E-MAIL

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

**Re: Quality One Care Home Health, Inc.
Certificate of Need Application (Anne Arundel, Montgomery, Prince George's, &
Southern Counties Region)**

Dear Ms. Shaw-Taylor:

Enclosed please find six (6) hard copies of the Certificate of Need (CON) Application submitted on behalf of Quality One Care Home Health, Inc. (QOC) to establish a Medicare-certified Home Health Agency serving Anne Arundel County, Montgomery County, Prince George's County, Calvert County, Charles County and St. Mary's County.

In accordance with Maryland Health Care Commission (MHCC) requirements, a full searchable PDF and Microsoft Word version of the application, along with the required Excel tables will also be submitted electronically via e-mail to mhcc-confilings@maryland.gov.

Quality One Care Home Health, Inc. is a Maryland-licensed Residential Service Agency (RSA License No. R3057) in good standing and is accredited by The Joint Commission. This submission represents QOC's intent to establish a Medicare-certified Home Health Agency to provide skilled home health services upon licensure and certification, consistent with COMAR 10.24.16.06(B)(3).

I hereby certify that a copy of this CON application has been provided to each affected local health department, as required.

If any additional information is needed, please let us know.

Sincerely,

Amon Chafukira
Program Coordinator
Quality One Care Home Health, Inc.

APPLICATION FOR CERTIFICATE OF NEED

For Establishment of a New Maryland Medicare-Certified Home Health Agency
Serving Anne Arundel County, Montgomery County, Prince George's County, Calvert County, Charles
County and St. Mary's County.

Applicant:

QUALITY ONE CARE HOME HEALTH, INC.

RSA License No. R3057

Accredited by The Joint Commission

Submitted to:

The Maryland Health Care Commission

4160 Patterson Avenue

Baltimore, Maryland 21215-2299

Date of Submission:

January 9, 2026

Prepared by:

Quality One Care Home Health, Inc.

9221 Colesville Road

Silver Spring, MD 20910

Tel: (301) 658-7141 | Email: msmatope@gmail.com



Randolph S. Sergent Esq, Chairman
Ben Steffen, Executive Director

Revised July 2024

**INSTRUCTIONS FOR
APPLICATION FOR CERTIFICATE OF NEED
HOME HEALTH AGENCY PROJECTS**

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

REQUIRED FORMAT:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively.

The Table of Contents must include:

- **Responses to PARTS I, II, III and IV of this application form**
- **Responses to PART II must include responses to the standards in the State Health Plan chapter, COMAR 10.24.16, STATE HEALTH PLAN FOR FACILITIES AND SERVICES: HOME HEALTH AGENCY SERVICES.**
- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.)

SUBMISSION FORMATS:

We require submission of application materials in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.¹ All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.
- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to mhcc-confilings@maryland.gov

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

¹ PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. APPLICANT. *If the application has a co-applicant, provide the following information for that party in an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee):
Quality One Care Home Health, Inc

Address:
9221 Colesville Silver Spring 20910 Maryland Montgomery
Road
Street City Zip State County

Telephone: 301-658-7141

Name of Owner/Chief Executive: Mohamed Matope, Director

2. Name of Owner Quality One Care Home Health, Inc

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

3. FACILITY

Name of HHA provider: Quality One Care Home Health, Inc

Address:
9221 Colesville Road Silver Spring 20910 Montgomery
Street City Zip County

Name of Owner (if differs from applicant):
SAME

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from the applicant:

SAME

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

- A. Governmental
- B. Corporation
 - (1) Non-profit
 - (2) For-profit
- Partnership
 - Date and State of Incorporation Maryland, April 21, 2011
- C. General
 - Limited
 - Limited Liability Partnership
 - Limited Liability Limited Partnership
 - Other (Specify):
 - Limited Liability Company
- D. Other (Specify): _____
- E. _____
- To be formed:
- Existing:

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Amon Chafukira, Program Coordinator
 Mailing Address: _____
9221 Colesville Road Silver Spring 20910 Maryland
 Street City Zip State
 Telephone: 301-658-7141
 E-mail Address (required): msmatope@gmail.com
 Fax: 301-658-2328

B. Additional or alternate contact:

Mohamed Matope
 Mailing Address: _____
9221 Colesville Road Silver Spring 20910 Maryland
 Street City Zip State
 Telephone: 301-658-7141
 E-mail Address (required): msmatope@gmail.com
 Fax: 301-658-2328

B. Additional or alternate contact:

Name and Title: _____

Company Name _____

Mailing Address: _____

Street _____ City _____ Zip _____ State _____

Telephone: _____

E-mail Address (required): _____

Fax: _____

**If company name
is different than
applicant briefly
describe the
relationship**

7. Proposed Agency Type:

- a. Health Department
 - b. Hospital-Based
 - c. Nursing Home-Based
 - d. Continuing Care Retirement Community-Based
 - e. HMO-Based
 - f. Freestanding
 - g. Other
- (Please Specify.) _____

8. Agency Services (Please check all applicable.)

Service	Currently Provided	Proposed to be Provided in the Jurisdiction(s) that are the subject of this Application*
Skilled Nursing Services	√	√
Home Health Aide	√	√
Occupational Therapy		√
Speech, Language Therapy		√
Physical Therapy		√
Medical Social Services		√

* All core services, including Medical Social Services, will be available throughout the proposed six-county service area: Anne Arundel County, Montgomery County, Prince George’s County, Calvert County, Charles County, and St. Mary’s County.

9. Offices

Identify the address of all existing main office, and branch office locations and identify the location (city and county) of all proposed main office, and branch offices, as applicable. (Add rows as needed.)

	Street	City	County	State	Zip Code	Telephone
Existing Main Office	9221 Colesville Road	Silver Spring	Montgomery	Maryland	20910	301-658-7141
Existing Branch Offices						
Locations of Proposed HHA Main Office	9221 Colesville Road	Silver Spring	Montgomery	Maryland	20910	301-658-7141
Locations of Proposed Branch Office	TBD*	Waldorf	Charles County	Maryland	20601	301-658-7141

* **Street:** TBD (to be secured prior to first use and reported to MHCC in accordance with applicable requirements)

10. Project Implementation Schedule for an HHA

An application for a CON or other Commission approval shall propose a schedule for implementation of the project in accordance with COMAR 10.24.01.12A(1) that specifies the estimated time for, at a minimum, the following project implementation steps: Obligation of Capital Expenditure, Beginning Construction, Complete Construction and Full Operation.

In developing the schedule, please note that COMAR 10.24.01.12C requires a holder to obligate at least 51 percent of the approved capital expenditure for a project involving building construction, renovation, or both, as documented by a binding construction contract or equipment purchase order, within the following specified time periods:

- An approved new hospital has up to 36 months
- A project involving an approved new non-hospital health care facility or involving a building addition or replacement of building space of a health care facility has up to 24 months
- A project limited to renovation of existing building space of a health care facility has up to 18 months
- A project that does not involve construction or renovation shall document that the approved project is complete and operational within 18 months.

In a multiphase plan of construction with more than one construction contract approved for an existing health care facility, a holder has:

(a) Up to 12 months after approval to obligate 51 percent of the capital expenditure for the first phase of construction

(b) Up to 12 months after completion of the immediately preceding phase of construction to obligate 51 percent of the capital expenditure for any subsequent approved phase

For Home Health projects, please also provide:

- A. Licensure: 6 months from CON approval date.
B. Medicare Certification 3 months from CON approval date.

APPLICANT RESPONSE: Project Implementation Schedule (Home Health Agency)

QOC's proposed project does **not** involve construction or renovation. Therefore, the project will be implemented and fully operational **within 18 months** of CON approval, consistent with COMAR 10.24.01.12A and 10.24.01.12C.

- **Obligation of Capital Expenditure:** Within 3 months of CON approval, QOC will obligate capital expenditures through executed vendor contracts and purchase orders for EHR implementation, IT/telecommunications, office equipment, and required start-up supplies.
- **Beginning Construction:** Not applicable (no construction/renovation).
- **Complete Construction:** Not applicable (no construction/renovation).
- **Licensure:** Within 6 months of CON approval.
- **Medicare Certification:** Within 3 months following State licensure (and completion of readiness and initial compliance preparations), and no later than 9 months from CON approval.
- **Full Operation:** Within 9–12 months of CON approval, following licensure and Medicare certification.

11. Project Description:

Provide a summary description of the project immediately below. At minimum, include the jurisdictions to be served and all of the types of home health agency services to be established, expanded, or otherwise affected if the project receives approval.

APPLICANT RESPONSE:

Project Description: Anne Arundel, Montgomery, Prince George's, and Southern Region (Calvert, Charles, and St. Mary's Counties)

Quality One Care Home Health, Inc. (QOC) seeks approval to establish a new Maryland-licensed, Medicare-certified Home Health Agency (HHA) serving Anne Arundel County, Montgomery County, Prince George's County, and the Southern Maryland Region (Calvert County, Charles County, and St. Mary's County) as a unified multi-jurisdictional service area. The proposed HHA will be a distinct licensed entity separate from QOC's existing Maryland-licensed Residential Service Agency (RSA License No. R3057), consistent with COMAR 10.24.16.06(B)(3).

The purpose of the proposed project is to expand access to cost-effective, high-quality, patient-centered Medicare home health services, particularly for medically complex, aging, and underserved residents across the six-county region, by adding additional Medicare-certified provider capacity and improving service availability, continuity of care, and consumer choice.

Organizational and Foundational Background

QOC has operated continuously since 2009 and was incorporated as Quality One Care Home Health, Inc. in 2011. QOC provides skilled and supportive home-based services across multiple Maryland jurisdictions and currently serves more than 200 clients annually, demonstrating established operational infrastructure, administrative capacity, and readiness to transition into Medicare-certified home health operations.

The Maryland Health Care Commission's (MHCC) FY 2023 Home Health Agency Utilization Tables demonstrate substantial service utilization across the six-county region. MHCC reports that the region served a combined total of **51,258 home health clients** (MHCC Table 17) and generated **779,489 total home health visits** in FY 2023 (MHCC Table 19). This volume of demand, combined with MHCC findings indicating limited high-performing provider choice in certain jurisdictions and market concentration concerns, supports the need for additional Medicare-certified home health provider capacity.

Services to be Provided

The proposed HHA will offer the full complement of Medicare-covered home health disciplines, including:

- Skilled Nursing Services
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Medical Social Services
- Home Health Aide Services

All services will be furnished pursuant to physician orders and coordinated through an individualized interdisciplinary plan of care, consistent with Medicare Conditions of Participation for Home Health Agencies (42 CFR Part 484). QOC will utilize evidence-based clinical protocols, QAPI processes aligned with Joint Commission standards, and an integrated electronic health record (EHR) system to support compliance, care coordination, and quality oversight. Where appropriate, care coordination tools (e.g., telephonic follow-up and remote monitoring functions integrated into care management workflows) may be used to support timely interventions and reduce preventable utilization; these tools will complement, not replace, the provision of skilled home health disciplines under the plan of care.

Implementation and Access

The proposed project does not involve construction or renovation and requires only routine start-up purchases (e.g., EHR/IT implementation, office equipment, and clinical supplies) consistent with the project budget and financial projections. QOC's headquarters in Silver Spring (Montgomery County) will serve as the primary administrative center. QOC also plans to establish a satellite office location in Southern Maryland to strengthen accessibility and operational oversight in Calvert, Charles, and St. Mary's Counties.

Upon Certificate of Need approval, QOC will begin implementation immediately, with Maryland HHA licensure targeted **within six (6) months** of approval, Medicare certification pursued promptly thereafter following readiness and initial compliance preparations, and full-service operation targeted **within twelve (12) months**. QOC has the financial stability, administrative infrastructure, and experienced leadership necessary to support a timely launch of Medicare-certified home health services without disruption to its current RSA operations.

QOC is committed to advancing health equity by expanding access to **Medicare-covered home health services** for low-income, minority, and medically complex populations across the six-county service

area. The agency will recruit and retain a locally representative and culturally competent workforce to improve care coordination, support adherence to care plans, and reduce avoidable hospital utilization. QOC will collaborate with hospital discharge planners, primary care practices, assisted living communities, and community-based organizations to strengthen care transitions, reduce preventable readmissions, and ensure timely access to skilled home health services, including for patients who historically experience delays due to payer type, limited provider capacity, transportation barriers, or caregiver availability. QOC's intake process will incorporate structured social determinants of health (SDOH) screening and referral pathways to address barriers such as transportation, food insecurity, medication access, language needs, and home safety concerns.

This project supports MHCC's State Health Improvement Process (SHIP) priorities by improving continuity of care in the home and expanding equitable access to community-based services for older adults and other high-need residents.

Relationship Between Existing RSA and Proposed Home Health Agency (HHA)

Quality One Care currently operates a licensed Residential Service Agency (RSA). The proposed Home Health Agency will be established and operated as a **distinct program and licensure line**, with its own **Administrator, clinical leadership structure, policies and procedures, patient care documentation, and billing operations** specific to Medicare-certified home health services. While the RSA and proposed HHA will share common corporate ownership and may share certain administrative support functions (e.g., human resources, IT support), the HHA will maintain **separate accounting records, cost centers, and patient care records** to ensure compliance with applicable Home Health Agency requirements and to prevent commingling of RSA and HHA operations. The HHA's governing body will retain authority over home health operations, quality oversight, and compliance functions.

- 1. Staffing Plan**

RSA staff will not be counted toward HHA staffing unless formally reassigned and trained under HHA job descriptions.

- 2. Financial Feasibility / Assumptions**

HHA operations will be tracked under a distinct cost center; shared administrative expenses will be allocated using a documented methodology.

- 3. Policies (Medicare CoPs / Admissions/Discharge)**

HHA policies apply only to HHA patients; RSA policies apply only to RSA clients.

**PART II – CONSISTENCY WITH REVIEW
CRITERIA AT COMAR 10.24.01.08G(3)**

PART II - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. These criteria follow, 10.24.01.08G(3)(b) through 10.24.01.08G(3)(h).

10.24.01.08G(3)(a). “The State Health Plan” Review Criterion

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria. (Note: HHA CON review standards may be found in COMAR 10.24.16.08. Furthermore, in a comparative review, CON preference rules may be found in COMAR 10.24.16.09

10.24.16.08 Certificate of Need Review Standards for Home Health Agency Services.

The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new home health agency in Maryland or expand the services of an existing Maryland home health agency to one or more additional jurisdictions.

The following standards must be addressed by all home health agency CON applicants, as applicable. Provide a direct, concise response explaining the proposed project's consistency with each standard. In cases where standards require specific documentation, please include the documentation as a part of the application.

10.24.16.08A. Service Area.

An applicant shall:

- (1) Designate the jurisdiction or jurisdictions in which it proposes to provide home health agency services; and**

APPLICANT RESPONSE – 10.24.16.08A(1):

10.24.16.08A(1). Service Area: Anne Arundel, Montgomery, Prince George's, and Southern Maryland Region

Quality One Care Home Health, Inc. (“QOC”) designates the Anne Arundel, Montgomery, Prince George’s, and Southern Maryland Region as the proposed service area for this Certificate of Need (CON) application. This six-county grouping is the unified multi-jurisdictional review area identified by the Maryland Health Care Commission (MHCC) in the 2025 Schedule One Home Health Agency Review Cycle.

The proposed service area includes:

- Anne Arundel County
- Montgomery County
- Prince George’s County
- Calvert County
- Charles County
- St. Mary’s County

This region reflects a large, diverse, and growing population base with significant demand for Medicare-certified home health services.

According to the Maryland Health Care Commission's 2023 Home Health Agency Utilization Tables, residents of these six counties accounted for:

- **51,258 home health clients** (MHCC Table 17: Total Home Health Clients by Jurisdiction)
- **779,489 total home health visits** (MHCC Table 19: Total Home Health Visits by Jurisdiction)

These combined totals represent a substantial portion of statewide utilization and demonstrate a consistently high need for skilled home-based clinical services across the region.

MHCC's age-specific utilization data further indicate that a significant share of home health service users in all six counties are adults 65 years and older, reflecting a high concentration of older and medically complex populations requiring skilled nursing, chronic disease management, and rehabilitative therapies (MHCC Table 24: Home Health Clients by Age Group). The demographic and utilization patterns of this six-county region, particularly the large Medicare populations in Montgomery and Prince George's Counties and the rural access challenges in Calvert, Charles, and St. Mary's Counties, support treating the area as a single, high-demand, multi-jurisdictional service region for this HHA application.

Based on these utilization patterns and MHCC findings, the region meets the criteria under COMAR 10.24.16.04, indicating insufficient consumer choice among quality-performing home health agencies and, in certain jurisdictions, highly concentrated markets.

QOC currently operates as a Maryland-licensed Residential Service Agency (RSA License No. R3057), providing skilled and non-skilled home-based nursing and supportive care across multiple Maryland counties, including Montgomery, Prince George's, Anne Arundel, Charles, Calvert, and St. Mary's. Through this operational footprint, QOC has developed extensive experience in multi-jurisdictional service delivery, regulatory compliance, and workforce deployment in both suburban and rural clinical environments.

The proposed expansion will enable QOC to deliver Medicare-certified home health services throughout the Anne Arundel–Montgomery–Prince George's–Southern Maryland region, addressing the documented need for coordinated, high-quality, home-based clinical care and improving access for underserved and medically complex populations.

- (2) **Provide an overall description of the configuration of the parent home health agency and its interrelationships, including the designation and location of its main office, and each branch, as defined in this Chapter, or other major administrative offices recognized by Medicare.**

APPLICANT RESPONSE– 10.24.16.08A(2):

10.24.16.08A(2). Configuration of the Parent Agency and Interrelationships

Quality One Care Home Health, Inc. (“QOC”) will operate the proposed Medicare-certified Home Health Agency under its existing corporate structure, with all Medicare-certified home health operations headquartered at:

- 9221 Colesville Road
Silver Spring, Maryland 20910 (Montgomery County)
Email: info@qualityonecare.com | Phone: (301) 658-7141 | Fax: (301) 658-2328

The Silver Spring office serves as QOC’s main corporate office and will function as the parent home health agency as defined under Medicare Conditions of Participation (42 CFR §484.105). The headquarters houses all administrative, clinical, quality-management, compliance, and corporate governance functions. All operational activities associated with the Medicare-certified HHA, including intake, scheduling, OASIS coordination, quality assurance, clinical oversight, billing, and staff supervision, will be centrally directed and managed from this location.

Branch and Satellite Configuration

QOC does not currently operate any Medicare-recognized branch offices. For the proposed six-county service area, the Silver Spring parent office will maintain full administrative and clinical oversight of all home health operations.

To support access and improve operational efficiency in Southern Maryland, QOC plans to establish a satellite administrative office in Charles County. This location will serve Calvert, Charles, and St. Mary’s Counties by supporting local staff coordination, case management, and community engagement. It will not function as a Medicare-certified branch at the outset but may be designated as one in the future should operational volume and CMS criteria justify branch status under 42 CFR §484.

Service Delivery and Oversight Model

QOC will deploy a mobile, field-based workforce of licensed registered nurses, rehabilitation therapists, medical social workers, and home health aides who will deliver direct patient care throughout Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties. This model

aligns with Maryland home health practice standards and supports efficient community-based service delivery across large multi-jurisdictional regions.

QOC will continue to operate under its Joint Commission–aligned Quality Assurance and Performance Improvement (QAPI) program and established corporate governance structure. Oversight of Medicare-certified home health operations will be provided by the Administrator and Director of Nursing, both based at the Silver Spring headquarters, supported by supervisory nurses and remote/virtual case-management capabilities to ensure timely clinical decision-making, documentation compliance, and regulatory oversight.

An organizational chart outlining administrative structure, reporting relationships, and lines of authority is provided in **Exhibit 1**.

10.24.16.08B. Populations and Services.

An applicant shall describe the population to be served and the specific services it will provide.

APPLICANT RESPONSE – 10.24.16.08B:

10.24.16.08B. Populations and Services: Anne Arundel, Montgomery, Prince George's, and Southern Region

The applicant, Quality One Care Home Health, Inc. (QOC), provides the following description of the population to be served and the specific services it will deliver, in compliance with COMAR 10.24.16.08B.

(1) POPULATION TO BE SERVED

Quality One Care Home Health, Inc. (QOC) proposes to serve residents of the six-county region: Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties. These jurisdictions include a mix of suburban population centers and rural communities with limited provider availability. Together, they comprise a service area of more than **2.4 million residents**, including some of Maryland's fastest-growing older adult populations and communities with significant chronic disease burden.

This region represents a large, diverse, and medically complex population with high utilization of Medicare-covered home health services, significant chronic disease burden, and persistent geographic access barriers, particularly in Southern Maryland.

REGIONAL UTILIZATION AND DEMOGRAPHIC NEED

To provide a clear and data-driven profile of the population to be served, QOC analyzed FY 2023 MHCC Home Health Agency Utilization Tables (Tables 17, 19, 20, and 24). The findings below demonstrate substantial, sustained demand for skilled home health care across the six-county area.

Table B-1: Medicare Utilization Percentages by County

(MHCC Table 20 – Percent Distribution of Home Health Visits by Payer, FY 2023)

County	Medicare Traditional	Medicare Advantage	Combined Medicare %
Anne Arundel	10.06%	6.55%	16.61%
Montgomery	14.25%	15.19%	29.44%
Prince George's	11.67%	21.28%	32.95%
Calvert	1.01%	0.37%	1.38%
Charles	1.60%	1.19%	2.79%
St. Mary's	1.61%	0.45%	2.06%

Montgomery and Prince George's Counties alone account for more than 62% of all statewide Medicare home health visits, indicating extremely high reliance on Medicare-certified HHAs. Southern Maryland counties show lower absolute percentages but represent high Medicare dependency per capita, due to smaller populations and limited provider supply.

These Medicare utilization patterns underscore two critical structural realities of the six-county region:

- (1) **Service demand is overwhelmingly Medicare-driven**, with Montgomery and Prince George's Counties alone accounting for more than 62% of statewide Medicare home health visits; and
- (2) **Southern Maryland counties exhibit high per-capita Medicare dependency**, despite their lower absolute percentages, because limited provider supply forces residents to rely heavily on the few Medicare-certified agencies that serve the area.

This combination of high-volume Medicare hubs and rural Medicare-dependent communities reinforces the region's designation as a multi-jurisdictional review area with a demonstrated need for additional Medicare-certified home health capacity.

Table B-2. Total Home Health Visits by County

(MHCC Table 19 – Total Number of Home Health Visits, FY 2023)

County	Total Visits (FY 2023)	Key Need Indicators
Anne Arundel	175,627	Aging suburban population; high chronic disease prevalence
Montgomery	270,550	Very large Medicare population; major hospital discharge volume
Prince George's	260,690	Medically complex population; MHCC-designated insufficient provider choice
Calvert	17,358	Rural access barriers; limited HHA availability
Charles	29,238	Significant growth; underserved areas; moderate HHA capacity
St. Mary's	26,026	High utilization relative to size; rural geography; discharge dependency

From the data above, we can see that together, these six counties generated **779,489 home health visits** in FY 2023 (MHCC Table 19), demonstrating the region's scale of utilization and validating MHCC's designation of multiple counties as having **insufficient choice among quality-performing HHAs or highly concentrated markets** under COMAR 10.24.16.04.

Table B-3: Six-County Home Health Utilization Summary

(MHCC Tables 17, 19, 24, 20)

Measure	Value	MHCC Source
Total home health clients	51,258	Table 17
Total home health visits	779,489	Table 19
Predominant age group	65+ (majority of users)	Table 24
Dominant payer	Medicare (≈92% of statewide visits)	Table 20

MHCC Table 20 shows that **Medicare Traditional (47.09%) and Medicare Advantage (45.31%) account for approximately 92% of all home health visits statewide**, underscoring the region's dependence on Medicare-certified HHAs and confirming the critical need for additional providers capable of serving Medicare beneficiaries.

Population Served & Regional Needs

Across the region, home health utilization reflects a population characterized by:

(1) Older Adults (65+) – The Core User Group

MHCC Table 24 confirms that seniors represent the bulk of home health clients statewide and within each of the six counties. These individuals often manage multiple chronic illnesses (HF, COPD, diabetes), require post-acute follow-up, and benefit greatly from skilled nursing and therapy delivered in the home.

(2) High Chronic Disease Burden

Chronic conditions drive recurring episodes of care and ongoing monitoring needs. Montgomery, Prince George's, Anne Arundel, and Southern Maryland counties have among the highest chronic disease prevalence rates in the state.

(3) Hospital Discharge Dependency

Prince George's and Montgomery Counties discharge large volumes of Medicare patients annually, directly increasing demand for home health services.

(4) Rural Access Challenges in Southern Maryland

Calvert, Charles, and St. Mary's Counties face:

- Longer travel distances
- Fewer Medicare-certified providers
- Higher per-capita Medicare dependency
- Documented limited provider choice

(5) Payer Mix Dominated by Medicare

With Medicare representing **~92% of statewide home health utilization**, the region is structurally dependent on Medicare-certified HHAs. QOC's proposed certification directly addresses this payer-driven need.

The six-county region exhibits a payer landscape overwhelmingly driven by Medicare utilization. MHCC Table 20 shows that Montgomery (29.44% Medicare) and Prince George's Counties (32.95% Medicare) together account for more than 62% of all statewide Medicare home health visits, reflecting exceptionally high reliance on Medicare-certified providers. At the same time, Southern Maryland counties, though smaller, demonstrate high Medicare dependency per capita due to limited provider supply and rural access constraints. These patterns confirm that the region's service demand is structurally tied to Medicare, reinforcing the need for expanded Medicare-certified home health capacity.

Specific Services to Be Provided

QOC will provide the full range of Medicare-covered home health services required under **42 CFR §484**, delivered under physician orders and supported by an interdisciplinary plan of care:

- **Skilled Nursing:** Assessment, chronic disease management, wound/ostomy care, medication management, infusion therapy, safety and education.
- **Physical Therapy:** Mobility training, strengthening, functional recovery, fall-prevention strategies.
- **Occupational Therapy:** Activities of Daily Living (ADLs) support, functional restoration, home environment safety.
- **Speech-Language Pathology:** Dysphagia treatment, communication therapy, cognitive-linguistic rehabilitation.
- **Medical Social Services:** Psychosocial evaluation, resources linkage, counseling, support for social determinants of health.
- **Home Health Aide Services:** Personal care, hygiene assistance, supervised functional support.
- **Remote Patient Monitoring (RPM):** Physiological monitoring to support chronic disease stabilization.
- **Chronic Care Management (CCM):** Longitudinal care coordination for patients with multiple chronic illnesses.

All services will be delivered through QOC's Joint Commission–aligned Quality Assurance and Performance Improvement (QAPI) program, supported by an integrated electronic health record and centralized oversight from QOC's Silver Spring headquarters.

The combined utilization patterns, high Medicare dependency, large visit volume, predominantly older population, and rural access challenges, clearly demonstrate that the six-county region represents a single, high-demand, multi-jurisdictional service area with longstanding gaps in home health capacity. These structural factors reinforce the need for an additional Medicare-certified Home Health Agency to ensure equitable access, continuity of care, and improved population health outcomes across the region.

10.24.16.08C. Financial Accessibility.

An applicant shall be or agree to become licensed and Medicare- and Medicaid-certified and agree to maintain Medicare and Medicaid certification and to accept clients whose expected primary source of payment is either or both of these programs.

APPLICANT RESPONSE – 10.24.16.08C:

10.24.16.08C. Financial Accessibility

Quality One Care Home Health, Inc. (QOC) is a Maryland-licensed Residential Service Agency (RSA License No. R3057). Upon approval of this Certificate of Need, QOC will become licensed as a Maryland home health agency and will obtain Medicare certification for the proposed Home Health Agency serving the Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's County region. QOC currently participates in the Maryland Medicaid Program, including the Model Waiver Program, and has extensive experience delivering skilled and non-skilled home-based services to Medicaid beneficiaries and dual-eligible clients across multiple Maryland jurisdictions.

Commitment to Public Payers

QOC affirms its unequivocal commitment to obtain and maintain both Medicare and Medicaid certification for the proposed Home Health Agency, in full compliance with all applicable State and federal regulations. The agency will accept all eligible patients regardless of their expected primary source of payment, including Medicare, Medicaid, Medicaid Managed Care, commercial insurance, and self-pay arrangements. Accordingly, QOC will accept clients whose expected primary source of payment is Medicare, Medicaid, or both programs.

Participation in both Medicare and Medicaid is essential for serving the six-county region, where a substantial proportion of home health users rely on public insurance. According to the MHCC FY 2023 Home Health Agency Utilization Tables, Medicare (Traditional and Advantage) and Medicaid account for the majority of home health clients statewide and within the proposed service area. This includes 20,111 Medicare Advantage clients and 1,462 Traditional Medicaid clients residing in the six-county region (MHCC Table 17). For many older adults, individuals with disabilities, dual-eligible beneficiaries, and low-income households, Medicare and Medicaid are the primary, and often the only, mechanisms for accessing medically necessary home health services.

QOC's commitment to maintaining certification in both programs ensures uninterrupted access to skilled nursing, rehabilitative therapy, medical social work, and home health aide services for these populations.

Compliance and Equitable Access

QOC's financial policies align with the Maryland State Health Plan's goals of promoting equity, affordability, and continuity of care. QOC maintains long-established administrative practices that ensure transparent and compliant billing procedures, timely verification of insurance benefits, and comprehensive assistance to patients and families in understanding Medicare and Medicaid coverage requirements. The agency routinely coordinates with Medicare and Medicaid case managers, hospital discharge planners, and managed care organizations to secure required authorizations and ensure timely initiation of services.

To support financial accessibility, QOC maintains internal processes designed to prevent cost from becoming a barrier to care. These include:

- Clear communication of financial obligations and coverage criteria
- Verification of benefits before service initiation
- Payment arrangement options for self-pay clients
- Dedicated staff who assist patients in navigating Medicare and Medicaid benefits
- Compliance programs ensuring adherence to federal, State, and payer-specific billing requirements

QOC's acceptance of publicly insured patients and commitment to maintaining Medicare and Medicaid certification will ensure that financially vulnerable and medically complex residents across the six-county region, particularly older adults and individuals with disabilities, have access to the full scope of Medicare-certified home health services without experiencing financial or administrative barriers.

10.24.16.08D. Fees and Time Payment Plan.

An applicant shall make its fees known to prospective clients and their families at time of patient assessment before services are provided and shall:

- (1) Describe its special time payment plans for an individual who is unable to make full payment at the time services are rendered; and**

APPLICANT RESPONSE – 10.24.16.08D (1):

Quality One Care Home Health, Inc. (QOC) will make its fee schedule for home health services known to all prospective clients and their families at the time of the initial patient assessment and prior to the start of care. Before services are initiated, QOC will provide each client with a written explanation of applicable service rates, billing practices, and available payment options, consistent with COMAR

10.24.16.08D and QOC's Financial Accessibility and Billing Policy (see Exhibit 2 – Time Payment Plan Policy).

QOC offers a dedicated Time Payment Plan for individuals who are unable to make full payment at the time services are rendered. The purpose of this plan is to ensure that inability to pay in full does not delay or restrict access to medically necessary home health services. Under this plan, clients may arrange installment payments through an interest-free, no-fee payment schedule, typically structured as equal monthly payments over a period not to exceed six (6) months. Longer payment periods may be approved by the Administrator in cases of documented financial hardship.

Services will not be denied or delayed based solely on a client's inability to pay immediately. Each client approved for time payment will receive a written payment agreement outlining the total amount due, installment schedule, due dates, and client responsibilities. Documentation of the agreement will be maintained in accordance with agency billing procedures and made available to the Maryland Health Care Commission upon request.

To support financial accessibility, QOC staff will assist clients and families in understanding coverage options, verifying benefits with Medicare, Medicaid, and third-party insurers, and identifying available financial assistance resources when appropriate. These practices promote transparency, reduce financial barriers to care, and support equitable access to home health services across the proposed service area.

- (2) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.**

APPLICANT RESPONSE – 10.24.16.08D (2):

Quality One Care Home Health, Inc. (QOC) will submit to the Maryland Health Care Commission (MHCC) a written **Time Payment Plan Policy** that details:

- I. The agency's time payment options for clients who are unable to make full payment at the time services are rendered, and
- II. the mechanisms by which clients may arrange for time payment.

The written policy is submitted to the Commission as **Exhibit 2 – Time Payment Plan Policy**.

QOC will also provide a written copy of the Time Payment Plan Policy to each client **during the admission process**, and **prior to the initiation of any privately billed services**, consistent with **COMAR 10.24.16.08D(2)**.

Time Payment Plan Policy (Exhibit 2)

QOC maintains a written Time Payment Plan Policy that provides flexibility through installment and deferred payment arrangements and includes the following provisions:

- **Eligibility:** Clients who demonstrate an inability to pay the full private-pay balance at the time of service may request a time payment arrangement.
- **Request Process and Client Notice:** During intake, financial review, or the billing process, QOC billing staff (or a designated financial counselor) will explain available payment options and provide the client with the written Time Payment Plan Policy.
- **Payment Terms:** Payment plans may be structured as equal monthly installments, typically not exceeding **six (6) months**, with longer extensions available upon approval by the Administrator in cases of documented financial hardship.
- **No Interest or Administrative Fees:** Time payment arrangements are **interest-free** and carry **no administrative fees**.
- **No Service Denial:** Services will not be denied or delayed solely because a client is unable to pay in full at the time services are rendered.
- **Written Agreement and Documentation:** The payment plan terms will be documented in a written agreement signed by the client (or authorized representative). A copy of the signed agreement will be provided to the client, and documentation will be retained in the client's billing record in accordance with agency procedures and made available to MHCC upon request.

The policy establishes a clear and consistent mechanism for arranging time payment, including the role of billing staff in assessing eligibility, preparing payment plan documents, obtaining signatures, and maintaining documentation. Payment plan terms are mutually agreed upon and confirmed in writing before or during service delivery, as appropriate.

In addition, QOC's financial team assists clients and families in understanding coverage options, verifying Medicare, Medicaid, and private insurance benefits, and identifying available payment assistance resources when applicable. These practices promote financial clarity and help ensure timely access to medically necessary home health services regardless of a client's immediate ability to pay.

Projected Private-Pay Fee Schedule (Exhibit 3)

QOC will also provide clients with a written fee schedule and private-pay rate disclosures during admission. The projected private-pay fee schedule is submitted as **Exhibit 3 – Projected Private-Pay Fee**

Schedule and is intended to promote transparency and clarity for clients who receive services outside of Medicare or Medicaid coverage.

Through these policies and procedures, QOC ensures that clients receive clear written notice of charges and payment options and that time payment arrangements are available and operationalized in a consistent, documented, and client-centered manner, supporting equitable access to home health services regardless of ability to pay at the time services are rendered.

10.24.16.08 E. Charity Care and Sliding Fee Scale.

Each applicant for home health agency services shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to home health agency services regardless of an individual's ability to pay and shall provide home health agency services on a charitable basis to qualified indigent and low-income persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

APPLICANT RESPONSE - 10.24.16.08 E:

Quality One Care Home Health, Inc. (QOC) maintains and will implement a formal written policy governing charity care and reduced-fee services for eligible clients. This policy ensures that inability to pay does not delay or restrict access to medically necessary home health services, consistent with COMAR 10.24.16.08E. The written Charity Care and Sliding Fee Scale Policy is submitted as **Exhibit 4 – Charity Care and Sliding Fee Scale Policy**.

- (1) Determination of Eligibility for Charity Care and Reduced Fees. Within two business days following a client's initial request for charity care services, application for medical assistance, or both, the home health agency shall make a determination of probable eligibility for medical assistance, charity care, and reduced fees, and communicate this probable eligibility determination to the client.**

APPLICANT RESPONSE - 10.24.16.08 E (1):

Determination of Eligibility for Charity Care and Reduced Fees

In accordance with COMAR 10.24.16.08E(1), QOC will ensure a rapid and documented eligibility determination process for clients who request charity care, apply for Medical Assistance, or request reduced fees.

- **Probable Eligibility Determination:** Within **two (2) business days** of a client's initial request for charity care, application for Medical Assistance, or both, QOC will make a determination of **probable eligibility** for Medical Assistance, charity care, and/or reduced fees.
- **Immediate Communication:** QOC will communicate the probable eligibility determination to the client (or authorized representative) immediately upon completion so that **care is not delayed** due to financial uncertainty.
- **Documentation:** All determinations and supporting documentation will be maintained in the client's financial record in accordance with agency procedures.

(2) **Notice of Charity Care and Sliding Fee Scale Policies. Public notice and information regarding the home health agency's charity care and sliding fee scale policies shall be disseminated, on an annual basis, through methods designed to best reach the population in the HHA's service area, and in a format understandable by the service area population. Notices regarding the HHA's charity care and sliding fee scale policies shall be posted in the business office of the HHA and on the HHA's website, if such a site is maintained. Prior to the provision of HHA services, a HHA shall address clients' or clients' families concerns with payment for HHA services and provide individual notice regarding the HHA's charity care and sliding fee scale policies to the client and family.**

APPLICANT RESPONSE - 10.24.16.08 E (2):

Notice of Charity Care and Sliding Fee Scale Policies

Consistent with COMAR 10.24.16.08E(2), QOC will provide continuous, accessible notice of its charity care and sliding fee scale policies to ensure that clients and families are aware of available financial assistance.

- **Annual Dissemination:** QOC will disseminate public notice and information regarding charity care and sliding fee scale policies **at least annually**, using methods designed to reach the target population in a format they can understand.
- **Posting Requirements:** Notices will be permanently posted in QOC's business office and will be prominently available on QOC's website.
- **Individual Notice Prior to Services:** Prior to the provision of services, QOC staff will address payment concerns with clients and families and provide **individual notice** of charity care and sliding fee scale options, including instructions for requesting assistance and submitting supporting documentation.

- (3) **Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy.** Each HHA's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income clients who do not qualify for full charity care but are unable to bear the full cost of services.

APPLICANT RESPONSE - 10.24.16.08 E (3):

Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy

In accordance with COMAR 10.24.16.08E(3), QOC will provide reduced-fee services for clients who do not qualify for full charity care but lack sufficient resources to pay the full private-pay rate.

- **Sliding Fee Scale:** QOC will apply a tiered sliding fee scale based on the **Federal Poverty Guidelines (FPG)** to determine eligibility for reduced fees.
- **Full Charity (100% discount):** Available for clients with incomes at or below **200% of the FPG**.
- **Partial Discounts:** Graduated discounts are available for clients with incomes between **200% and 400% of the FPG**.
- **Coordination with Time Payment Plans:** Clients who qualify for discounted care may also utilize QOC's **interest-free Time Payment Plan** described in Section 10.24.16.08D, ensuring that reduced fees are paired with manageable payment options when appropriate.

This approach ensures financial assistance is operationalized in a consistent, transparent, and equitable manner while maintaining continuity of care.

- (4) **Policy Provisions.** An applicant proposing to establish a home health agency or expand home health agency services to a previously unauthorized jurisdiction shall make a commitment to, at a minimum, provide an amount of charity care equivalent to the average amount of charity care provided by home health agencies in the jurisdiction or multi-jurisdictional region it proposes to serve during the most recent year for which data is available. The applicant shall demonstrate that:
- (a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and
 - (b) It has a specific plan for achieving the level of charity care to which it is committed.

APPLICANT RESPONSE- 10.24.16.08 E (4):

QOC makes a binding commitment to provide charity care and reduced-fee services in an amount at least equivalent to the average level provided by home health agencies serving the applicable multi-jurisdictional review area comprised of Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties, based on the most recent year for which MHCC data are available.

(a) Track Record and Credibility of Commitment.

Although QOC currently operates as a Maryland-licensed Residential Service Agency (not yet Medicare-certified as a home health agency), it has an established record of serving Medicaid beneficiaries, dual-eligible residents, and low-income households throughout Maryland and has long maintained financial assistance policies to prevent inability to pay from limiting access to medically necessary home-based care. This history supports the credibility and feasibility of QOC's charity care and reduced-fee commitment for the proposed Medicare-certified HHA.

(b) Specific Plan to Achieve the Committed Charity Care Level.

QOC will track charity care and reduced-fee services monthly, including the dollar value of charity care and discounts provided and the number of clients served, with review conducted by the Administrator and billing/financial staff through routine compliance and financial oversight processes. Performance summaries will be maintained in internal records and reviewed to confirm that QOC meets its commitment. If performance is below the committed level, QOC will implement corrective actions, including expanded outreach and referral coordination with local Departments of Social Services, hospital discharge planners, community-based organizations, and managed care partners to identify and enroll additional eligible clients and increase awareness of available assistance.

These monitoring and corrective action procedures are designed to ensure QOC meets or exceeds the regional charity care benchmark required under COMAR 10.24.16.08E(4), as outlined below.

- **Regional Benchmark Commitment (Six-County Review Area):** QOC commits to providing charity care in an amount at least equivalent to the average level provided by home health agencies serving the applicable multi-jurisdictional review area comprised of Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties, based on the most recent year for which MHCC data are available.
- **Implementation and Monitoring:** QOC will monitor charity care and reduced-fee utilization monthly through internal tracking and management review, including the dollar value of charity care

and reduced-fee discounts provided and the number of clients receiving assistance, to ensure performance meets its commitment.

- **Corrective Action:** If QOC determines that it is not meeting its charity care commitment, it will implement corrective actions, including expanded outreach and referral coordination with local Departments of Social Services, hospital discharge planners, community-based organizations, and managed care partners to identify and enroll additional eligible clients.
- **Organizational Credibility:** QOC's existing history as a Maryland-licensed Residential Service Agency demonstrates ongoing service delivery to Medicaid beneficiaries and low-income residents, supporting the credibility and feasibility of this commitment.

Through Exhibit 4 and the related operational procedures described above, QOC ensures that charity care and reduced-fee services are clearly communicated, timely determined, consistently documented, and made accessible to eligible clients throughout the six-county service area.

10.24.16.08 F. Financial Feasibility.

An applicant shall submit financial projections for its proposed project that must be accompanied by a statement containing the assumptions used to develop projections for its operating revenues and costs. Each applicant must document that:

- (1) **Utilization projections are consistent with observed historic trends of HHAs in each jurisdiction for which the applicant seeks authority to provide home health agency services;**

APPLICANT RESPONSE- 10.24.16.08 F (1):

Consistency of Utilization Projections with Historic Trends

Quality One Care Home Health, Inc. (QOC) has developed utilization projections for the proposed Medicare-certified Home Health Agency that are conservative, achievable, and consistent with observed historic home health utilization trends in the six-county review area comprised of Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties.

QOC's projections are informed by the Maryland Health Care Commission's (MHCC) 2023 Home Health Agency Utilization Tables and reflect the region's documented baseline demand for Medicare-certified home health services.

Table F-1: Six-County Historic Home Health Utilization Snapshot (FY 2023)

(MHCC Home Health Agency Utilization Tables, FY 2023)

Measure	FY 2023 Value (Six-County Total)	MHCC Source
Total Home Health Clients	51,258	Table 17
Total Home Health Visits	779,489	Table 19
Dominant Payer Source (Statewide Visits)	Medicare Traditional (47.09%) + Medicare Advantage (45.31%) = 92.40%	Table 20
Predominant Age Group	Adults 65+ represent a substantial share of home health service users statewide and within the region	Table 24

As shown above, MHCC data confirm that the six-county region generates sustained home health demand, with high overall utilization volume and strong reliance on Medicare certified services. These established utilization trends support the reasonableness of QOC’s projected admissions and visit volumes and demonstrate that the proposed project is grounded in the region’s historic service needs.

Table F-2. Total Home Health Visits by County (FY 2023)

(MHCC Table 19 – Total Number of Home Health Visits, FY 2023)

County	Total Home Health Visits (FY 2023)
Anne Arundel	175,627
Montgomery	270,550
Prince George’s	260,690
Calvert	17,358
Charles	29,238
St. Mary’s	26,026
Six County Total	779,489

County-level utilization further demonstrates that the proposed service area includes both high-volume jurisdictions (Montgomery and Prince George’s Counties) and smaller Southern Maryland counties where home health services remain essential to maintaining access to post-acute and community-based care. Together, these MHCC utilization patterns confirm that QOC’s projected utilization ramp-up is consistent with the established demand profile of the six-county region and reflects realistic operational assumptions regarding staffing, referral development, and service capacity.

Accordingly, QOC's utilization projections are consistent with observed historic trends for home health agencies in each jurisdiction for which the applicant seeks authority, satisfying the requirements of COMAR 10.24.16.08F(1). The utilization assumptions used to develop QOC's financial projections, including projected admissions and visit volumes, are provided in **Exhibit 5 – Financial Tables and Statement of Assumptions**.

- (2) **Projected revenue estimates are consistent with current or anticipated charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving each proposed jurisdiction; and**

APPLICANT RESPONSE- 10.24.16.08 F (2):

Consistency of Projected Revenue Estimates with Charge Levels, Reimbursement, Contractual Adjustments/Discounts, Bad Debt, and Charity Care

Quality One Care Home Health, Inc. (QOC) developed projected revenue estimates for the proposed Medicare-certified Home Health Agency using assumptions for charge levels, reimbursement rates, contractual adjustments and discounts, bad debt, and charity care provision that reflect current Maryland market conditions and the recent experience of Medicare-certified home health agencies serving the six-county review area comprised of Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties. Because QOC is a newly proposed home health agency, the revenue assumptions draw on publicly reported Maryland Health Care Commission (MHCC) data, CMS Home Health Prospective Payment System (HH PPS) reimbursement methodology, and prevailing Maryland Medicaid and commercial payer payment standards.

- **Medicare (HH PPS) Reimbursement Assumptions:** Medicare reimbursement assumptions are based on the HH PPS payment structure and reflect the Medicare payment methodology applicable to home health agencies, including case-mix weights, Low Utilization Payment Adjustment (LUPA) thresholds, and the applicable wage index. These assumptions ensure that projected Medicare revenues reflect amounts consistently realized by comparable home health agencies operating in Maryland under the same reimbursement framework. MHCC payer mix patterns (Table 20) indicate that Medicare (Traditional plus Medicare Advantage) accounts for the large majority of home health visits, supporting the reasonableness of Medicare-related assumptions as the dominant driver of projected revenues.
- **Medicaid and Commercial Reimbursement Assumptions:** Medicaid reimbursement assumptions incorporate Maryland Medicaid home health payment practices, including fee-for-service and managed care arrangements where applicable. Commercial insurance revenue

estimates reflect typical contracted rates and standard contractual reductions (such as negotiated discounts and payer-specific denials), consistent with the experience of Maryland home health agencies serving similar jurisdictions.

- **Charge Levels and Benchmarking to Maryland Experience:** To ensure projected revenue estimates are consistent with current or anticipated charge levels, QOC benchmarked projected per-visit charges using MHCC statewide average per-visit charges by discipline (FY 2023), which reflect actual reported experience of Maryland home health agencies. These benchmark values support the reasonableness of the projected private-pay charges disclosed to clients in **Exhibit 3 – Private Pay Fee Schedule** and used as a baseline for revenue modeling where private-pay charges apply.

Table F-3: Maryland Statewide Average Per-Visit Charges by Discipline (FY 2023)

(MHCC Home Health Agency Annual Survey Utilization Tables, FY 2023 – Table 9: Total Visits and Average Cost Per Visit by Discipline and Home Health Agency)

Service Type (Per Visit)	Statewide Avg. Charge
Skilled Nursing	\$126.48
Physical Therapy	\$136.92
Occupational Therapy	\$141.72
Speech Therapy	\$154.61
Medical Social Work	\$175.42
Home Health Aide	\$58.31

Contractual Adjustments, Discounts, Bad Debt, and Charity Care

QOC’s projections include reasonable allowances for contractual adjustments and discounts, bad debt, and charity care consistent with the recent experience of Maryland home health agencies. Contractual adjustments and discounts are applied to account for standard payer-specific reductions and negotiated rate differentials. Bad debt assumptions are incorporated to reflect expected non-collectible balances consistent with typical home health revenue realization patterns. Charity care and sliding-fee-scale discounts are incorporated based on QOC’s formal financial assistance policies and commitment, as documented in **Exhibit 4 – Charity Care and Sliding Fee Scale Policy**, and are reflected as reductions to gross charges consistent with standard accounting and reimbursement practices.

Collectively, these assumptions ensure that QOC's projected revenue estimates are consistent with (1) current or anticipated charge levels, (2) reimbursement rates and payment structures applicable to Medicare, Medicaid, and commercial payers, and (3) contractual adjustments and discounts, bad debt, and charity care provision, consistent with the recent experience of Maryland home health agencies serving the proposed jurisdictions. The detailed revenue projections, underlying assumptions, and supporting financial tables are provided in **Exhibit 5 – Financial Tables and Statement of Assumptions**, with supporting policy documentation provided in **Exhibit 3 – Private Pay Fee Schedule** and **Exhibit 4 – Charity Care and Sliding Fee Scale Policy**

- (3) **Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving each proposed jurisdiction.**

APPLICANT RESPONSE - 10.24.16.08 F (3):

Consistency of Staffing and Overall Expense Projections with Utilization Projections and Maryland HHA Experience

Quality One Care Home Health, Inc. (QOC) developed staffing and overall expense projections for the proposed Medicare-certified Home Health Agency to ensure they are consistent with the utilization projections presented in response to COMAR 10.24.16.08F(1) and are based on current expenditure levels and reasonably anticipated future staffing levels. Because QOC is a newly proposed home health agency, these projections reflect the recent experience of Medicare-certified home health agencies operating in Maryland, including agencies serving the six-county review area comprised of Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties.

QOC's staffing model was developed using a phased ramp-up approach that aligns staffing levels with projected admissions, visit volumes, and service mix by discipline. Staffing assumptions reflect:

- **Expected visit volumes** based on MHCC utilization patterns in the six-county region (FY 2023) and QOC's conservative market-entry projections
- **Discipline-specific productivity standards** (visits per full-time equivalent (FTE)) consistent with Maryland home health operations
- **Patient acuity and service mix**, with staffing allocations across skilled nursing, therapy disciplines, medical social work, and home health aide services
- **Compliance with Medicare Conditions of Participation** and applicable State licensure requirements, including requirements for supervision, documentation, and care coordination

This approach ensures QOC does not overstaff in early years while maintaining sufficient clinical capacity to meet projected demand, accept referrals promptly, and deliver safe, timely, and compliant home health services.

QOC's overall expense projections are based on current and reasonably anticipated cost experience for Maryland home health agencies, including wage levels, benefit costs, operational support staffing, and non-labor operating costs. Expense categories included in QOC's projections consist of:

- **Direct clinical labor** (nursing, therapy, aide, and social work staff)
- **Clinical supervision and care coordination**
- **Administrative and billing staff** required to support Medicare compliance, authorization management, claims submission, and collections
- **Employee benefits, payroll taxes, and worker-related costs**
- **Medical supplies and patient care materials**
- **Insurance, professional fees, rent, utilities, IT systems, and general administrative costs**
- **Transportation and mileage reimbursement** to support service delivery across the six-county region

To ensure reasonableness, QOC modeled staffing-related expenditures using market-based wage assumptions and operational benchmarks reflective of Maryland home health agencies and adjusted for the geographic distribution of service delivery in both high-volume jurisdictions (Montgomery and Prince George's Counties) and smaller Southern Maryland counties (Calvert, Charles, and St. Mary's).

Staffing Feasibility and Operational Readiness

QOC's projections reflect a realistic staffing strategy that supports recruitment and retention, including:

- Competitive wage assumptions aligned with Maryland workforce conditions
- Use of discipline-appropriate staffing ratios and scalable hiring tied to utilization growth
- Administrative capacity to support clinical staff productivity (scheduling, billing, compliance, and referral intake)
- Training and competency oversight consistent with Medicare-certified agency operations

This staffing strategy supports continuity of care and helps ensure that growth in visit volume does not outpace staffing capacity.

Accordingly, QOC's staffing and overall expense projections are consistent with its utilization projections and are based on reasonably anticipated staffing and expenditure levels, consistent with the recent experience of other Maryland Medicare-certified home health agencies serving the proposed six-county review area. Detailed staffing assumptions, projected expense categories, and supporting financial tables are provided in **Exhibit 5 – Financial Tables and Statement of Assumptions**, with supporting organizational and staffing policies provided in **Exhibit 1 – Organizational Chart** and **Exhibit 13 – Staffing and Staff Development Policy**.

Staffing productivity assumptions (visits per FTE), wage and benefit assumptions, and overhead cost percentages used to project total operating expenses are documented in Exhibit 5 and were developed using recent Maryland Medicare-certified home health agency operating benchmarks applicable to each county in the six-county review area.

10.24.16.08G. Impact.

An applicant shall address the impact of its proposed home health agency service on each existing home health agency authorized to serve each jurisdiction or regional service area affected by the proposed project. This shall include impact on existing HHAs' caseloads, staffing and payor mix.

APPLICANT RESPONSE - 10.24.16.08 G: IMPACT

Quality One Care Home Health, Inc. ("QOC") evaluated the potential impact of the proposed home health agency on existing HHAs that currently serve **Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties**. The impact analysis addresses:

- i. Existing agencies' caseloads (clients and visits),
- ii. Staffing capacity and workforce impacts, and
- iii. Payor mix and payer distribution.

QOC relied on MHCC's **Maryland Home Health Agency Annual Survey for Fiscal Year 2023**, including **Table 13** (unduplicated clients by jurisdiction, payment source, and agency), **Table 14** (visits based on unduplicated clients by jurisdiction, payment source, and agency), **Table 17** (county totals for unduplicated clients), and **Table 19** (county totals for visits).

QOC's proposed project is designed to expand access and meet demand across the six-county service area. QOC's entry will not materially destabilize existing providers' caseloads, staffing, or payer mix because:

1. The service area reflects substantial baseline utilization.
2. Multiple agencies currently serve each county.
3. QOC's planned scale is modest relative to the overall market.

1. Impact on Existing HHAs' Caseloads (Clients and Visits)

QOC evaluated the impact of the proposed project on the caseloads of existing HHAs authorized to serve each of the six jurisdictions. MHCC data demonstrate that the six-county service area supports high existing utilization across multiple providers, which limits the magnitude of any potential market share effects and supports the conclusion that QOC's entry will be absorbed primarily through **new and unmet demand**, rather than displacement of existing caseloads.

Table G-1: Six-County Historic Home Health Utilization Snapshot (FY 2023)

(Source: MHCC FY 2023 Utilization and Cost Report, Table 17, Table 19)

Measure	FY 2023 Value (Six-County Total)	MHCC Source
Total Home Health Clients	51,258	Table 17
Total Home Health Visits	779,489	Table 19
Payment Source Distribution (Visits)	Medicare Traditional (47.09%) + Medicare Advantage (45.31%) = 92.40% (Maryland Total)	Table 20
Predominant Age Group	Adults 65+ represent a substantial share of users	Table 24

The FY 2023 baseline volume in the six-county region reflects substantial current demand for home health services, and that demand is expected to continue as the region experiences population growth, aging trends, and increasing prevalence of chronic conditions. QOC's entry is designed to improve access and continuity of care, especially for patients who face barriers due to payer type, language needs, homebound limitations, and geographic access constraints. QOC's proposed service model expands service options without materially reducing caseloads at any single incumbent agency. Given this baseline utilization, QOC's projected volume represents a small incremental share of service area demand and is expected to be absorbed primarily through unmet need, new referrals, and patient choice, rather than material displacement from any single incumbent provider.

Table G-2: Current Utilization Baseline by Jurisdiction (FY 2023)

Source: **MHCC FY 2023 Utilization and Cost Report, Table 17 (clients) and Table 19 (visits).**

Jurisdiction	Unduplicated Clients (FY 2023)	Total Home Health Visits (FY 2023)	MHCC Source
Anne Arundel County	11,770	175,627	Table 17; Table 19
Montgomery County	19,575	270,550	Table 17; Table 19
Prince George’s County	14,616	260,690	Table 17; Table 19
Calvert County	1,355	17,358	Table 17; Table 19
Charles County	2,322	29,238	Table 17; Table 19
St. Mary’s County	1,620	26,026	Table 17; Table 19
TOTAL	51,258	779,489	Table 17; Table 19

To further quantify impact, QOC compared its projected annual visit volume at full ramp-up to FY 2023 baseline home health visit volumes in each jurisdiction (MHCC Table 19). Even assuming QOC’s full ramp-up volume is concentrated within the six-county service area, QOC’s projected share of total visits in each jurisdiction remains small relative to established utilization.

Table G-3. QOC Projected Visit Share by County

Formula:

$$\text{QOC Projected Annual Visits in County} \div \text{FY 2023 Total Home Health Visits in County (MHCC Table 19)} = \text{QOC Share of County Visits}$$

Jurisdiction	FY 2023 Total Home Health Visits (MHCC Table 19)	QOC Projected Annual Visits in County (CY 2028)	QOC Share of County Visits
Anne Arundel County	175,627	1,320 (1,294 billable + 26 non-billable)	0.75%
Montgomery County	270,550	2,205 (2,161 billable + 44 non-billable)	0.81%
Prince George’s County	260,690	1,650 (1,617 billable + 33 non-billable)	0.63%
Calvert County	17,358	450 (441 billable + 9 non-billable)	2.59%
Charles County	29,238	780 (764 billable + 16 non-billable)	2.67%
St. Mary’s County	26,026	540 (529 billable + 11 non-billable)	2.07%
TOTAL	779,489	6,945	0.89%

When compared to FY 2023 baseline visit totals in each county, QOC’s projected annual visit volume at full utilization represents only a small fraction of total home health utilization in the three large jurisdictions and a modest share in the smaller jurisdictions. Accordingly, QOC does not expect its entry to materially reduce caseloads at incumbent agencies. Rather, QOC expects its volume to be achieved

through a combination of unmet demand, additional referral capacity, patient choice, and improved access for underserved populations, consistent with the purpose of the State Health Plan home health standards.

In addition, QOC's projected volume is expected to be distributed across a multi-provider environment in each county, as reflected by the agencies reported in MHCC Tables 13 and 14. For this reason, the incremental visit share attributable to QOC will not be concentrated against any single incumbent agency and is therefore not expected to have a material adverse impact on any existing HHA's operational sustainability, staffing, or payer mix.

Consistent with QOC's Table 2B assumptions, projected utilization reflects a conservative ramp-up and does not assume rapid displacement of existing providers or immediate high-volume capture in any single jurisdiction.

QOC's market entry assumptions were deliberately conservative, including low penetration rates in larger jurisdictions and gradual growth over three years, with an average of 15.21 visits per client applied consistently across jurisdictions and a 98% billable and 2% non-billable split.

2. Impact on Existing HHAs' Staffing (Workforce Capacity)

QOC evaluated potential staffing impacts by reviewing the existing staffing environment across home health agencies serving Maryland and the six-county region. QOC will staff the proposed agency through a phased hiring plan aligned with patient census growth and will use a mixed staffing approach including recruitment of new staff entering the home health market and contracted clinical resources as needed. QOC's staffing plan is designed to minimize disruption to incumbent agencies while supporting timely service delivery across all six jurisdictions.

QOC's staffing approach is grounded in the following operational strategies:

- **Phased hiring tied to census and visit volume.** QOC will scale patient care FTEs in proportion to growth in service volume.
- **Multiple recruitment channels.** QOC will recruit through local health workforce pipelines, community-based networks, and professional recruitment platforms that draw candidates beyond any single incumbent provider.
- **Use of contracted clinical resources when appropriate.** QOC may use contract therapy, contract nursing coverage, and contract aide support during ramp-up periods to maintain service continuity without creating concentrated recruitment pressure on one or two incumbent providers.

- **Retention and workforce stability policies.** QOC will implement onboarding, training, and retention practices that support workforce stability and reduce turnover-related competition.
- **Quality and data compliance support.** QOC will ensure adequate administrative support for OASIS submission, quality reporting, and HHCAHPS requirements through internal staff and or qualified vendors, consistent with regulatory expectations and operational best practice.

Even at full ramp-up, QOC’s projected patient care staffing represents a small proportion of the total staffing base reflected in MHCC utilization and staffing reporting. As a result, QOC’s entry is not expected to materially disrupt staffing capacity at incumbent agencies serving the six-county region.

TABLE G-4: Staffing Baseline

Selected Major HHAs Serving the Proposed Service Area (FY 2023 FTEs)

Agency Name	Registered / LPNs	Physical Therapists	Total Patient Care Personnel
Adventist Home Health Services	35.5	33.45	80.05
Bayada Home Health Care	52	64.5	151.75
Johns Hopkins Home Health Services	56.98	41.24	117.04
MedStar Health Home Care - Calverton	30.8	39.5	97.4
Revival Homecare Agency	20.25	25.75	55.77
(Source: MHCC Table 11)			

This table is illustrative of workforce scale and does not represent the complete list of HHAs serving each jurisdiction, which is provided in Table G-6 and highlights major providers serving the proposed service area to illustrate current workforce scale and the context for QOC’s phased recruitment plan.

QOC’s phased operational ramp-up and competitive retention strategies are intended to expand the local clinical talent pool. By focusing on professional development and a supportive culture, QOC aims to minimize any adverse impact on the staffing levels of incumbent agencies. QOC intends to implement a phased operational ramp-up, allowing for a gradual recruitment process that seeks to expand the local clinical talent pool rather than causing a detrimental drain on incumbent agencies.

Because QOC’s operational ramp-up is staged and tied to demonstrated demand, and because staffing assumptions are aligned with standard Maryland HHA operating benchmarks documented in

Exhibit 5 – Financial Tables and Statement of Assumptions, QOC does not anticipate material adverse staffing impacts on existing HHAs in the six-county service area.

Accordingly, QOC’s staffing plan is consistent with the recent experience of other Maryland Medicare-certified home health agencies serving the proposed jurisdictions and will not materially disrupt incumbent agencies’ staffing capacity.

3. Impact on Existing HHAs’ Payor Mix (Medicare/Medicaid/Commercial)

QOC evaluated impact on payor mix using MHCC FY 2023 payer distribution data (MHCC Table 13). The data demonstrate that Medicare is the dominant payer source for home health utilization in Maryland and that county-level payer distributions vary but remain stable across incumbent agencies. QOC’s proposed payer mix is consistent with the existing market composition and is designed to expand access, including for Medicaid and low-income populations, without shifting payer composition in a way that would destabilize incumbent agencies.

Table G-5
Payment Source Distribution by Jurisdiction (Unduplicated Clients, MHCC FY 2023)

Payment Source	Anne Arundel	Montgomery	Prince George’s	Calvert	Charles	St. Mary’s
Medicare (Traditional + Advantage)	9,886 (84.0%)	15,994 (81.7%)	11,383 (77.9%)	1,072 (79.1%)	1,868 (80.4%)	1,299 (80.2%)
Medicaid (Traditional + Managed Care)	248 (2.1%)	549 (2.8%)	666 (4.6%)	48 (3.5%)	107 (4.6%)	204 (12.6%)
Commercial Insurance	1,299 (11.0%)	2,593 (13.2%)	2,187 (15.0%)	217 (16.0%)	319 (13.7%)	181 (11.2%)
Other (Other Gov + Self Pay + Other)	337 (2.9%)	439 (2.2%)	367 (2.5%)	18 (1.3%)	28 (1.2%)	38 (2.3%)
TOTAL CLIENTS	11,770	19,575	14,616	1,355	2,322	1,620

Source: MHCC FY 2023 Utilization and Cost Report, Table 13 (Total Number of Clients by Jurisdiction of Residence, Payment Source, and Agency).

QOC’s projected payer mix is consistent with this baseline distribution. QOC’s charity care and sliding fee scale policies (Exhibit 4) support access for low-income and uninsured patients and are designed to expand access rather than shift payer composition in a way that would destabilize existing agencies.

Existing HHAs Serving Each Jurisdiction (Caseload Context)

Agencies Identified in MHCC FY 2023 Tables 13 and 14 as Authorized to Serve and or Reporting Volume in County. QOC's entry will occur within a market where multiple providers already serve each county.

Table G-6.

Existing Home Health Agencies Serving the Six-County Service Area (FY 2023)

County / Jurisdiction	Agencies Identified in MHCC FY 2023 Tables 13 and 14 as Serving County
Anne Arundel County	Amedisys Home Health of Maryland; Bayada Home Health Care; CenterWell Home Health; Community Home Health of Maryland; Comprehensive Home Health Services; HomeCall – Easton; HomeCentris Home Health II; Johns Hopkins Home Health Services, Inc.; Johns Hopkins Pediatrics at Home, Inc.; MedStar HealthHome Care – Baltimore; PHR of Baltimore, Inc.; Revival Home Care Agency – Baltimore; Stella Maris, Inc.; VNA of Maryland, LLC
Montgomery County	Adventist Home Health Services; Amedisys Home Health (Largo); Americare in Home Nursing; Asbury Home Services; Bayada Home Health Care (Montgomery); CenterWell Home Health; Community Home Health of Maryland; Comprehensive Home Health Care Agency; Enhabit Home Health (Montgomery County); Frederick Health Home Care; Holy Cross Home Care and Hospice; Home Health Connection; HomeCall – Frederick; Human Touch Home Health of Maryland; Johns Hopkins Pediatrics at Home, Inc.; MedStar Health Home Care – Calverton; Potomac Home Health Care; Professional Healthcare Resources of Maryland, Inc.; Revival Homecare Agency; Riderwood Home Health; VNA of Maryland, LLC
Prince George’s County	Adventist Home Health Services; Amedisys Home Health (Largo); Americare in Home Nursing; CenterWell Home Health; Community Home Health of Maryland; Holy Cross Home Care and Hospice; HomeCall – Easton; Human Touch Home Health of Maryland; Johns Hopkins Pediatrics at Home, Inc.; MedStar Health Home Care – Calverton; PHR of Maryland, Inc.; Potomac Home Health Care; Revival Homecare Agency; Riderwood Home Health; VNA of Maryland, LLC
Calvert County	Bayada Home Health Care; Chesapeake-Potomac Home Health Agency; HomeCall – Easton; Johns Hopkins Pediatrics at Home, Inc.; MedStar Health Home Care – Calverton; Minerva Home Health Care; VNA of Maryland, LLC
Charles County	Adventist Home Health Services; Chesapeake-Potomac Home Health Agency; HomeCall – Easton; Johns Hopkins Pediatrics at Home, Inc.; MedStar Health Home Care – Calverton; VNA of Maryland, LLC
St. Mary’s County	Chesapeake-Potomac Home Health Agency; HomeCall – Easton; Johns Hopkins Pediatrics at Home, Inc.; MedStar Health Home Care – Calverton; VNA of Maryland, LLC

Source: MHCC FY 2023 Utilization and Cost Report, Table 13 (clients by payer by agency by county) and Table 14 (visits by payer by agency by county).

These tables demonstrate that incumbent providers already serve each county and support the conclusion that QOC's entry will occur in a competitive multi-provider environment, reducing the likelihood of material adverse impact on any single incumbent agency.

Overall Impact

Based on MHCC FY 2023 utilization, payer distribution, and provider presence across the six-county region, QOC's proposed home health agency is expected to have **minimal adverse impact** on existing HHAs authorized to serve Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties.

The six-county region has substantial baseline utilization and multiple incumbent agencies serving each jurisdiction. QOC's entry will expand patient choice and service availability and will primarily address unmet demand, thereby improving access and continuity of care without materially reducing incumbent agencies' caseloads, staffing capacity, or payor mix stability.

10.24.16.08H. Financial Solvency.

An applicant shall document the availability of financial resources necessary to sustain the project. Documentation shall demonstrate an applicant's ability to comply with the capital reserve and other solvency requirements specified by CMS for a Medicare-certified home health agency.

APPLICANT RESPONSE- 10.24.16.08H: FINANCIAL SOLVENCY

Quality One Care Home Health, Inc. ("QOC") will establish and operate a new Medicare-certified home health agency and will maintain the financial resources necessary to sustain operations through start-up and ramp-up periods, including the period between initiation of care and receipt of reimbursement. QOC will fund start-up and operating needs through a combination of available internal resources and documented financial support, as applicable, and will maintain sufficient working capital to support patient care delivery, staffing, and administrative compliance functions. QOC's liquidity position supports the anticipated timing gap between service initiation and reimbursement, including during the Medicare certification period.

QOC's financial projections demonstrate that the proposed agency is expected to generate sufficient operating revenue to support ongoing operations and maintain financial stability as volume increases. QOC's projected operating costs include adequate staffing levels, administrative support, and contracted resources as necessary to ensure timely service delivery and compliance with Medicare conditions of participation and reporting requirements.

Availability of Financial Resources

QOC will maintain adequate working capital and reserves to cover payroll, benefits, clinical supplies, insurance, mileage, and other essential expenses during the period before full reimbursement cycles stabilize. QOC's financial solvency strategy includes the following:

- **Start-up and working capital reserve.** QOC will maintain reserves sufficient to support initial operations, including staffing ramp-up, training, and compliance readiness activities. As of December 31, 2023, QOC reported \$1,421,764 in cash and bank balances, \$1,814,513 in total assets, \$151,900 in total liabilities, and \$1,662,613 in total equity, demonstrating substantial liquidity and financial capacity to support start-up and ongoing operations.
- **Cash flow management.** QOC will implement billing and collections controls to ensure timely submission of Medicare claims and reconciliation of remittances, with ongoing monitoring of accounts receivable aging, cash balances, and expense obligations.
- **Conservative utilization assumptions.** QOC's volume projections reflect a gradual ramp-up and do not assume immediate high-volume market capture.
- **Contingency planning.** QOC will maintain contingency resources to support operations in the event of delays in Medicare reimbursement, lower than expected referral volume, or higher than expected staffing and administrative costs during start-up.

Compliance with CMS Solvency Requirements

QOC will comply with CMS requirements applicable to Medicare-certified home health agencies, including CMS financial solvency expectations and any applicable enrollment and certification financial documentation requirements. QOC will maintain sufficient liquid assets and working capital to meet ongoing operational obligations and will document compliance as required during Medicare enrollment and certification processes.

Supporting Documentation

QOC will provide documentation demonstrating access to sufficient financial resources to sustain the proposed project, including:

- financial statements and supporting schedules evidencing available resources and working capital capacity; and
- pro forma financial statements for the proposed home health agency demonstrating projected revenues, expenses, and cash flow sufficiency during start-up and ramp-up.

Based on the resources available to QOC and the projected performance of the proposed home health agency, QOC will have the financial capacity to sustain the project and comply with applicable CMS solvency requirements for Medicare-certified home health agencies.

10.24.16.08I. Linkages with Other Service Providers.

An applicant shall document its links with hospitals, nursing homes, continuing care retirement communities, hospice programs, assisted living providers, Adult Evaluation and Review Services, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

- (1) A new home health agency shall provide this documentation when it requests first use approval.**

APPLICANT RESPONSE- 10.24.16.08I(1):

Quality One Care Home Health, Inc. (“QOC”) will establish and operate a new Medicare-certified home health agency serving the six-county service area of Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties. QOC will develop and maintain linkages with health care and community service providers in each county to support coordinated transitions of care, timely referrals, and continuity of services for homebound individuals and other patients requiring skilled home health services.

Because QOC is a new home health agency, QOC will provide finalized linkage documentation at the time of first use approval, as required by COMAR 10.24.16.08I(1). In advance of first use, QOC has established initial referral pathways, partnerships, and coordination relationships that support linkage development across hospitals, community-based organizations, and school-based service systems, and will continue to formalize and expand these linkages throughout the six-county service area.

Current Linkages and Referral Pathways

QOC currently maintains relationships and referral pathways that support linkage development and coordinated care, including:

- **Children’s National Hospital** (referrals received through EnsoCare and other referral pathways)
- **The Johns Hopkins Hospital, Baltimore** (referrals received through Aiden and other referral pathways)
- **Prince George’s ARC** (community-based supports and service coordination)
- **The Coordinating Center for REM and Model Waiver** (care coordination and service linkage support)
- **Montgomery County Public Schools**

- **Prince George's County Public Schools**
- **Charles County Public Schools**
- **Frederick County Public Schools** (included as an existing linkage and referral source, outside the six-county proposed service area)

These relationships support referrals, care coordination, and linkage development for individuals with complex needs and for pediatric and school-aged populations requiring skilled services in the home and community settings.

Linkage Development Strategy

QOC will implement an organized linkage strategy to support patients and caregivers across the six-county service area:

- i. **Hospital and health system discharge planning coordination.**
QOC will engage discharge planners, care management teams, and referral platforms to support timely start of care, medication reconciliation, and reduction of avoidable readmissions.
- ii. **Coordination with community-based organizations.**
QOC will strengthen referral pathways with community organizations that support individuals with disabilities and complex needs, including care coordination programs and nonprofit service providers.
- iii. **School-based linkage coordination.**
QOC will continue coordination with county public school systems as appropriate to support continuity of care for children and adolescents receiving medically necessary services and related supports.
- iv. **Expansion of linkages with the full range of providers specified in COMAR 10.24.16.08I.**
QOC will expand and formalize linkages within each county with nursing facilities, assisted living providers, continuing care retirement communities, hospice programs, Adult Evaluation and Review Services, adult day care programs, Departments of Social Services, and home delivered meal programs.
- v. **Documentation and ongoing maintenance.**
QOC will maintain a linkage inventory and document relationships through executed agreements, letters of intent, referral protocols, or documented workflows, as applicable.

LINKAGE MATRIX (CURRENT AND TARGET LINKAGES)

Table I-1.
Current and Target Linkages by Provider Type and Jurisdiction

Provider or Organization	Type	Jurisdiction(s) Served	Nature of Linkage	Status
Children's Hospital (via EnsoCare and other pathways)	Hospital referral source	Six-county service area	Referrals received through EnsoCare platform	Active referral pathway
The Johns Hopkins Hospital (via Aiden and other pathways)	Hospital referral source	Six-county service area	Referrals received through referral platforms and hospital processes	Active referral pathway
Prince George's ARC	Community-based organization	Prince George's County	Service coordination and community-based linkage support	Partnership
REM Coordination Center	Care coordination organization	Six-county service area	Care coordination and linkage support	Partnership
Montgomery County Public Schools	School system	Montgomery County	Coordination for eligible pediatric or school-based service needs	Partnership
Prince George's County Public Schools	School system	Prince George's County	Coordination for eligible pediatric or school-based service needs	Partnership
Charles County Public Schools	School system	Charles County	Coordination for eligible pediatric or school-based service needs	Partnership
Frederick County Public Schools	School system	Outside proposed service area	Existing relationship, potential referral source outside service area	Partnership (non-service area)
Skilled Nursing Facilities	Nursing homes	All six counties	Post-acute transition and referral coordination	Target linkages
Assisted Living Providers and CCRCs	Assisted living, continuing care	All six counties	Step-down services, chronic care support, and prevention of institutional placement	Target linkages
Hospice Programs	Hospice	All six counties	Coordination for hospice evaluation and transitions of care	Target linkages
Adult Evaluation and Review Services	AERS	All six counties	Adult support coordination for individuals with complex needs	Target linkages
Adult Day Care Programs	Adult day care	All six counties	Day program coordination and caregiver support	Target linkages
Department of Social Services	DSS	All six counties	Linkages for benefits support, case management, and community resources	Target linkages
Home Delivered Meal Programs	Nutrition support	All six counties	Coordination to address nutrition needs and reduce avoidable complications	Target linkages

Documentation at First Use Approval

Consistent with COMAR 10.24.16.08I(1), QOC will submit finalized linkage documentation at the time of first use approval. This documentation will include executed agreements or letters, where available, and an updated linkage matrix identifying each provider, the county served, the type of linkage, and the operational coordination pathway for referrals and care transitions.

- (2) A Maryland home health agency already licensed, and operating shall provide documentation of these linkages in its existing service area and document its work in forming such linkages before beginning operation in each new jurisdiction it is authorized to serve.**

APPLICANT RESPONSE- 10.24.16.08I(2):

This provision is not applicable to Quality One Care Home Health, Inc. (QOC) because QOC is not yet a licensed or operating home health agency in Maryland. As a new HHA applicant, QOC is subject to the requirements outlined in COMAR 10.24.16.08I(1) and will provide full documentation of its formal linkages with hospitals, nursing homes, assisted living providers, AERS programs, local Departments of Social Services, and other community-based organizations at the time it requests first-use approval.

10.24.16.08J. Discharge Planning.

An applicant shall document that it has a formal discharge planning process including the ability to provide appropriate referrals to maintain continuity of care. It will identify all the valid reasons upon which it may discharge clients or transfer clients to another health care facility or program.

APPLICANT RESPONSE- 10.24.16.08J:

Quality One Care Home Health, Inc. ("QOC") will maintain a formal discharge planning process to ensure safe transitions of care, continuity of services, and appropriate referrals for all patients served by the proposed Medicare-certified Home Health Agency. Discharge planning will begin at admission and will be incorporated into the patient's individualized plan of care, including identification of clinical goals, caregiver support needs, and anticipated post-discharge service requirements. QOC's discharge planning process and discharge criteria are set forth in **Exhibit 12, Discharge Planning Policy**.

Discharge Planning Process

QOC's discharge planning process includes the following components:

1. **Planning initiated at admission.** At the start of care, QOC will assess the patient's clinical status, functional limitations, home environment, caregiver support, and community resource needs. The interdisciplinary care team will establish measurable goals and an expected discharge plan as part of the plan of care.
2. **Ongoing reassessment and care coordination.** QOC will reassess the patient's needs throughout the episode of care and will update the discharge plan as the patient's condition changes. Discharge planning includes communication with the patient, family or caregiver, and the ordering physician.
3. **Patient and caregiver education.** QOC will provide education on medication management, symptom monitoring, safety, and self-care strategies. When appropriate, QOC will include caregiver training to support safe ongoing care after discharge.
4. **Referrals to support continuity of care.** QOC will provide referrals as needed to ensure continuity of care. Referrals may include, as appropriate, primary care providers, specialists, outpatient therapy, durable medical equipment suppliers, hospice programs, nursing facilities, assisted living providers, community-based programs, Adult Evaluation and Review Services, local Departments of Social Services, home delivered meal programs, and other supportive services.
5. **Safe transition and documentation.** Prior to discharge or transfer, QOC will document the reason for discharge, the patient's status at discharge, the discharge instructions provided, and the referrals made. QOC will communicate discharge information to the ordering physician and other providers as appropriate to support continuity of care.

Valid Reasons for Discharge or Transfer

QOC may discharge a patient from home health services or transfer a patient to another provider or setting for valid reasons including, but not limited to, the following:

1. **Goals of care are met.** The patient has achieved the goals of the plan of care and no longer requires skilled home health services.
2. **No longer homebound or no longer requires skilled services.** The patient no longer meets eligibility criteria for home health services, including loss of homebound status or absence of need for skilled nursing or therapy services.

3. **Physician order.** The ordering physician discontinues home health services or orders transfer to another setting.
4. **Patient choice.** The patient requests discharge, refuses services, or chooses another provider.
5. **Inability to safely meet patient needs.** QOC determines it cannot safely meet the patient's needs in the home due to changes in clinical condition, home environment, caregiver support limitations, or other safety concerns, and appropriate referrals are made to alternative providers or higher levels of care.
6. **Hospitalization or institutional placement.** The patient is admitted to a hospital, nursing facility, assisted living facility, inpatient rehabilitation facility, or other setting where home health services are discontinued or require transfer coordination.
7. **Relocation outside the service area.** The patient moves outside QOC's approved service area and transfer to another provider is necessary.
8. **Non-compliance or disruptive behavior.** The patient's repeated non-compliance with the plan of care or disruptive behavior interferes with safe and effective service delivery, and discharge is conducted in accordance with applicable requirements and with referrals for continuing care as appropriate.
9. **Non-payment when applicable.** The patient fails to meet payment obligations for services that are not reimbursed or are subject to patient responsibility, and QOC provides appropriate notice and referrals consistent with applicable requirements and QOC's financial and charity care policies.
10. **Death.** The patient expires during the episode of care.

Continuity of Care Commitment

In all discharge or transfer circumstances, QOC will make appropriate referrals and will coordinate care transitions to support continuity of care. QOC will provide discharge instructions, notify the ordering physician, and document discharge planning and referrals in the patient record, consistent with **Exhibit 12, Discharge Planning Policy**.

Through these procedures, QOC ensures that each patient experiences a safe, coordinated transition at the conclusion of home health services, consistent with COMAR 10.24.16.08J and applicable Medicare Conditions of Participation for home health agencies.

10.24.16.08K. Data Collection and Submission.

An applicant shall demonstrate ongoing compliance or ability to comply with all applicable federal and State data collection and reporting requirements including, but not limited to, the Commission’s Home Health Agency Annual Survey, CMS’ Outcome and Assessment Information Set (OASIS), and CMS’ Home Health Consumer Assessment of Healthcare Providers (HCAHPS).

APPLICANT RESPONSE- 10.24.16.08K:

Quality One Care Home Health, Inc. (“QOC”) affirms its ability and commitment to comply with all federal and State data collection, reporting, and submission requirements applicable to Medicare-certified home health agencies. Upon licensure and Medicare certification, QOC will implement the systems, staffing, and procedures required to meet the Maryland Health Care Commission (“MHCC”) and the Centers for Medicare and Medicaid Services (“CMS”) reporting standards.

QOC will ensure ongoing compliance with the following required reporting programs:

- **MHCC Home Health Agency Annual Survey.** QOC will complete and submit all required utilization, staffing, financial, payer mix, and quality-related data in accordance with MHCC instructions and established timelines.
- **CMS Outcome and Assessment Information Set (OASIS).** QOC will use a CMS-compliant electronic health record platform to collect, validate, and transmit OASIS assessments for all applicable patients as required by CMS for quality measurement and Home Health Quality Reporting Program compliance. QOC’s EHR includes built-in validation and error-checking functions to support accurate submission.
- **CMS Home Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS).** QOC will contract with a CMS-approved HCAHPS survey vendor to administer patient experience surveys and submit required survey data to CMS in accordance with applicable CMS requirements and submission schedules.

QOC’s Administrator and designated quality and compliance personnel will oversee all reporting and submission requirements and will ensure that staff receive appropriate training. QOC will maintain internal controls to support timely submission, including reporting calendars, supervisory review of required data elements, and periodic audits of data integrity. QOC will also maintain appropriate privacy and security safeguards, including HIPAA-compliant policies, access controls, and business associate agreements with vendors as applicable.

Through these measures, QOC demonstrates the ability to comply with all data collection and submission requirements under **COMAR 10.24.16.08K.**

10.24.16.09 Certificate of Need Preference Rules in Comparative Reviews.

The Commission shall use the following preferences, in the order listed, to limit the number of CON applications approved in a comparative review.

APPLICANT RESPONSE- 10.24.16.09(A-E):

At the Pre-Application Conference, MHCC Staff confirmed that this project is not being reviewed as a Comparative Review. Therefore, the preference rules under COMAR 10.24.16.09A–E do not apply to this application.

10.24.16.09A. Performance on Quality Measures.

Higher levels of performance will be given preference over lower levels of performance.

APPLICANT RESPONSE- 10.24.16.09(A):

MHCC Staff determined that this is not a Comparative Review. Accordingly, the quality-measure preference rule under COMAR 10.24.16.09A is not applicable.

10.24.16.09B. Maintained or Improved Performance.

An applicant that demonstrates maintenance or improvement in its level of performance on the selected process and outcome measures during the most recent three-year reporting period will be given preference over an applicant that did not maintain or improve its performance.

APPLICANT RESPONSE- 10.24.16.09(A):

Because this project is not part of a Comparative Review, the preference rule regarding maintained or improved performance under COMAR 10.24.16.09B is not applicable.

10.24.16.09C. Proven Track Record in Serving all Payor Types, the Indigent and Low-Income Persons.

An applicant that served a broader range of payor types and the indigent will be given preference over an applicant that served a narrower range of payor types and provided less service to the indigent and low-income persons.

APPLICANT RESPONSE- 10.24.16.09(C):

As confirmed by MHCC Staff, this application is not subject to Comparative Review. Therefore, the preference rule under COMAR 10.24.16.09C does not apply.

10.24.16.09D. Proven Track Record in Providing a Comprehensive Array of Services.

An applicant that provided a broader range of services will be given preference over an applicant that provided a narrower range of services.

APPLICANT RESPONSE- 10.24.16.09(D):

Since MHCC Staff determined that this is not a Comparative Review, the preference provisions of COMAR 10.24.16.09D are not applicable.

10.24.16.09E. These preferences will only be used in a comparative review of applications when it is determined that approval of all applications that fully comply with standards in Regulation .08 of this Chapter would exceed the permitted number of additional HHAs provided for in a jurisdiction or multi-jurisdictional region as provided in Regulation .10.

APPLICANT RESPONSE- 10.24.16.09(E):

MHCC Staff confirmed that this application is not in a Comparative Review. Therefore, the "Preference Rules" in COMAR 10.24.16.09E are not applicable to this project.

10.24.01.08G(3)(b). The "Need" Review Criterion

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated a need for the proposed project.

INSTRUCTIONS: Fully address the way in which the proposed project is consistent with any specific applicable need standard or need projection methodology in the State Health Plan.

Please assure that all sources of information used in the need analysis are identified and identify all the assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), and the relevant population considered in the analysis with information that supports the validity of these assumptions. The existing and/or intended service area population of the applicant should be clearly defined.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D

must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

APPLICANT RESPONSE- 10.24.01.08G(3)(b): Need Review Criterion

Quality One Care Home Health, Inc. (“QOC”) proposes to establish a new Medicare-certified home health agency (“HHA”) to serve the MHCC-designated six-county review area consisting of Anne Arundel County, Montgomery County, Prince George’s County, Calvert County, Charles County, and St. Mary’s County. The proposed project is evaluated under the State Health Plan chapter for Home Health Agency Services (COMAR 10.24.16) and the Commission’s CON review criteria at COMAR 10.24.01.08G(3)(b).

QOC demonstrates need for the proposed project through objective utilization evidence and service characteristics documented in the MHCC Home Health Agency Annual Survey utilization tables for Fiscal Year 2023. MHCC data show that home health services are heavily utilized across the six-county region and that residents rely predominantly on Medicare-certified home health agency capacity. In FY 2023, the six-county region generated 51,258 unduplicated home health clients (MHCC Table 17) and 779,489 total home health visits (MHCC Table 19), confirming substantial and sustained demand for skilled home health services. The proposed QOC HHA will expand provider choice and strengthen access to Medicare-certified home health care across a diverse region that includes high-volume suburban jurisdictions and smaller Southern Maryland counties where geographic distance and limited provider availability can affect timely access to home health services.

QOC’s utilization projections are conservative and reflect gradual ramp-up typical for start-up HHAs. QOC’s projected volume represents a small share of total FY 2023 utilization in the six-county region and is not based on displacement of incumbent agency caseloads.

Service Area Definition and Relevant Population

- **Service Area**

QOC’s proposed service area is the six-county region consisting of Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties. All utilization references and projections in this need analysis are based on residents of these counties, consistent with the MHCC review area.

- **Relevant Population**

The need analysis focuses on residents of the six counties who utilize Medicare-certified home health services, including individuals who are homebound and require skilled nursing, therapy, or aide services under a physician plan of care. Older adults and medically complex individuals represent a significant portion of home health users, and the need analysis reflects the service demands associated with these populations.

Need Demonstrated by MHCC Utilization Data in the Six-County Region

Table F-2. Total Home Health Visits by County (FY 2023)

(MHCC Table 19 – Total Number of Home Health Visits, FY 2023)

County	Total Home Health Visits (FY 2023)
Anne Arundel	175,627
Montgomery	270,550
Prince George's	260,690
Calvert	17,358
Charles	29,238
St. Mary's	26,026
Six County Total	779,489

MHCC data confirm that Montgomery County and Prince George's County account for the highest visit volume in the six-county region. Southern Maryland counties (Calvert, Charles, and St. Mary's) also demonstrate sustained need, and their geographic characteristics support the importance of additional provider capacity and responsive referral acceptance.

Table G(3)-B

Unduplicated Home Health Clients by County (MHCC Table 17, FY 2023)

County	Unduplicated Home Health Clients (FY 2023)
Anne Arundel County	11,770
Montgomery County	19,575
Prince George's County	14,616
Calvert County	1,355
Charles County	2,322
St. Mary's County	1,620
Six-County Total	51,258

These county-level client totals confirm that demand is substantial and geographically distributed across the service area. The six-county region includes both high-volume jurisdictions and smaller counties where access to home health services can be constrained by provider availability and travel distance, supporting the need for an additional Medicare-certified HHA option.

Medicare-Certified Capacity is Essential in the Service Area

The MHCC FY 2023 payer distribution confirms that Medicare represents the dominant payer source for home health utilization and reinforces the importance of Medicare-certified agency capacity. Statewide, Medicare Traditional and Medicare Advantage account for the overwhelming majority of home health visits (MHCC Table 20). This payer structure indicates that home health service demand depends on Medicare-certified providers that can meet CMS Conditions of Participation, OASIS reporting requirements, and quality reporting obligations.

Sources of Information Used in the Need Analysis

QOC relied on the following sources to develop the need analysis:

1. **MHCC Home Health Agency Utilization Tables, Fiscal Year 2023**, including:
 - **Table 13:** Unduplicated clients by jurisdiction, payment source, and agency
 - **Table 14:** Visits by jurisdiction, payment source, and agency
 - **Table 17:** Total number of home health clients by jurisdiction of residence and payment source
 - **Table 19:** Total number of home health visits by jurisdiction of residence and payment source
 - **Table 20:** Distribution of visits by payment source
 - **Table 24:** Clients by age group
2. **QOC projection assumptions and operating plans**, including:
 - **Exhibit 5, Financial Tables and Statement of Assumptions**, and
 - **Statistical Projection worksheet Table E** included in the **CON Table Package** submitted with this application.

Assumptions Supporting the Need Analysis and Projections

Consistent with MHCC instructions, QOC identifies the following assumptions used in the need analysis and utilization projections:

1. **Service Area Basis.** The intended service area consists of Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties.

2. **Baseline Demand and Utilization Reference.** County-level home health utilization was referenced from MHCC FY 2023 Tables 17 and 19 to establish baseline demand for the service area.
3. **Market Penetration and Ramp-Up.** QOC's projected penetration is conservative and reflects gradual ramp-up constraints typical for start-up HHAs, including staffing growth, Medicare certification timelines, and referral development. QOC's projections assume:
 - For larger jurisdictions (Anne Arundel, Montgomery, and Prince George's): approximately **0.25 percent** penetration of FY 2023 county clients in Year 1, **0.50 percent** in Year 2, and **0.75 percent** in Year 3.
 - For smaller jurisdictions (Calvert, Charles, and St. Mary's): approximately **0.75 percent** penetration in Year 1, **1.50 percent** in Year 2, and **2.25 percent** in Year 3.
4. **Projected Utilization Rate.** QOC applied an average of **15.21 visits per client per year**, derived from MHCC FY 2023 totals for the six-county region (**779,489 total visits ÷ 51,258 unduplicated clients = 15.21 visits per client**).
5. **Billable and Non-Billable Visits.** QOC assumed **98 percent billable** and **2 percent non-billable** visits to reflect routine start-up inefficiencies and non-covered activities.
6. **Discipline Mix.** QOC's projected discipline mix reflects typical home health operating benchmarks and is documented in Exhibit 5 and the Table 2B projection worksheets.

These assumptions support conservative projections and do not assume immediate high-volume market capture. Even at Year 3 penetration levels, QOC's projected client volume represents a small share of the six-county region's FY 2023 utilization and is not based on displacement of incumbent provider caseloads.

Statistical Projection Worksheets (Tables D and E)

QOC has completed the required **Statistical Projection worksheet Table E** in the CON Table Package and has included Table E with this application submission, consistent with MHCC instructions for a new home health agency project. Table D is not applicable because QOC is a proposed new Medicare-certified home health agency and does not have historical utilization as an existing HHA.

Need Review Criterion Summary

MHCC FY 2023 utilization data demonstrate that the six-county review area is a large and diverse home health service region with sustained and high baseline demand, including **779,489 total visits** and **51,258 unduplicated clients**. Demand is distributed across major jurisdictions and Southern Maryland counties that experience geographic access constraints. The service area is structurally dependent on Medicare-certified home health agency capacity. QOC's projections are conservative, aligned with MHCC data, and reflect a modest share of existing utilization.

Based on the defined service area, documented utilization baseline, clearly stated assumptions, and completion of the required statistical projections, the proposed project is consistent with the State Health Plan objectives for home health agency services and satisfies the "Need" review criterion under **COMAR 10.24.01.08G(3)(b)**.

10.24.01.08G(3)(c). Alternatives to the Project Review Criterion

The Commission shall consider the alternative approaches to meeting the need identified for the project that were considered by the applicant in planning the project and the basis for the applicant's choice of the project among considered alternatives. In a comparative review of applications within the same review cycle, the Commission shall compare the costs and the likely effectiveness of alternative projects in meeting identified needs, improving the availability and accessibility of care, and improving the quality of care.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project, or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

APPLICANT RESPONSE- 10.24.01.08G(3)(c):

Quality One Care Home Health, Inc. (“QOC”) considered multiple approaches to meeting the need for expanded access to Medicare-certified home health services in the six-county region consisting of Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties.

QOC’s planning process focused on developing a project that would improve the availability and accessibility of home health services, strengthen continuity of care for medically complex patients, and support high-quality service delivery through compliance with Medicare Conditions of Participation, quality reporting requirements, and coordinated clinical operations.

In developing the proposed project, QOC evaluated alternatives based on effectiveness in meeting identified needs, feasibility of implementation, and both start-up and ongoing operating costs. QOC selected the proposed project, establishment of a new Medicare-certified home health agency, because it is the most effective and sustainable approach to expanding capacity and improving access within the service area while maintaining quality oversight and operational accountability.

Planning Process and Project Objectives

QOC’s planning process included review of MHCC home health utilization data for the six-county region, evaluation of the volume of home health clients and visits by county and payer source, assessment of service gaps affecting timely admissions and continuity of care, and development of operational and financial assumptions for staged ramp-up.

The primary objectives of the proposed project are to:

1. Expand access to Medicare-certified home health services across a large and diverse service area.
2. Improve continuity of care for patients transitioning from hospital and post-acute settings to home.
3. Increase provider choice, including for patients with complex needs and patients who require coordinated care planning.
4. Maintain high-quality service delivery through Medicare Conditions of Participation compliance, OASIS reporting, HHCAHPS participation, and a robust quality assurance framework.

Alternatives Considered and Basis for Selection

- **Alternative 1: Rely on Existing Medicare-Certified Home Health Agencies**

QOC considered the alternative of meeting service needs solely through existing Medicare-certified home health agencies currently operating in the service area. While existing agencies provide significant capacity, this alternative is less effective because it does not ensure timely access for all patients, particularly in high-volume jurisdictions and in Southern Maryland counties where geography and provider availability can affect admission timelines and continuity of services. Reliance solely on existing providers also does not expand consumer choice or introduce additional capacity to respond to sustained demand documented in MHCC utilization data.

- **Cost:** This alternative would not require start-up expenditures by QOC; however, it does not provide a direct mechanism to increase available provider capacity or to improve care coordination outcomes for QOC's target patient populations. Any improvements would depend on operational decisions by existing providers, and QOC would have limited ability to influence responsiveness, referral acceptance, staffing availability, and service continuity.
-
- **Effectiveness:** Moderate. Existing agencies will continue to serve the market, but this alternative does not directly expand capacity, reduce access barriers, or strengthen continuity of care through a dedicated provider structure.

- **Alternative 2: Contract With Existing Medicare-Certified Home Health Agencies for Service Delivery**

QOC considered the alternative of contracting with existing Medicare-certified home health agencies to deliver services to QOC-referred patients, rather than establishing a new agency. Under this alternative, QOC could develop referral relationships with existing agencies, but QOC would have limited control over staffing, scheduling, admission prioritization, care plan implementation, quality reporting, and patient experience processes. This alternative also limits QOC's ability to implement standardized clinical protocols and to ensure consistent service availability across the six-county region.

- **Cost:** This approach would shift costs to contract rates paid to existing agencies and would likely increase per-patient service delivery costs over time. Contracted service delivery would also limit QOC's ability to manage life cycle costs because contract pricing, staffing

availability, and service terms could change over time. In addition, this alternative would not create a durable provider platform capable of scaling to meet increasing demand and referral volume.

- **Effectiveness:** Moderate. Contracting could provide limited access to services, but would not ensure consistent availability, responsiveness, or quality oversight to the extent achievable through a directly operated Medicare-certified home health agency.
- **Alternative 3: Provide Only Non-Medicare Home-Based Services Without Medicare Certification**

QOC also considered limiting services to non-Medicare home-based support services, such as private duty or personal care services, without establishing a Medicare-certified HHA. This alternative would not meet the identified need because it does not expand access to Medicare-covered skilled nursing, therapy, and home health aide services that require Medicare certification. It would also exclude the predominant payer source for home health utilization, which is Medicare, and would not support continuity of care for post-acute patients who require skilled services ordered by a physician.

- **Cost:** This alternative would avoid Medicare certification costs, but it would constrain service scope and significantly limit patient access because most patients in need of skilled home health services rely on Medicare coverage. This alternative would also reduce the ability to serve medically complex patients and would not align with the regional utilization profile.
- **Effectiveness:** Low. It would not address the need for Medicare-certified home health services.
- **Alternative 4: The Proposed Project: Establish a New Medicare-Certified Home Health Agency**

QOC selected establishment of a new Medicare-certified home health agency as the preferred alternative because it is the most effective approach to improving availability and accessibility of home health services across the six-county region while ensuring strong quality oversight and continuity of care. The proposed project allows QOC to:

- Expand provider capacity and consumer choice in a high-utilization region.
- Implement standardized clinical protocols and a unified quality assurance framework.

- Ensure compliance with Medicare Conditions of Participation and reporting requirements, including OASIS and HHCAHPS participation.
 - Develop operational infrastructure to support timely admissions, care coordination, and effective discharge planning.
-
- **Cost:** The proposed project includes defined start-up and operating costs documented in the application's financial projections, including staffing, administrative infrastructure, compliance readiness activities, and working capital support during ramp-up. QOC's pro forma financial statements demonstrate sustainability over the initial operating years. Compared to ongoing contracting costs under Alternative 2, the proposed project provides a lower-cost life cycle operating structure through direct staffing, standardized workflows, and scalable operations.
 - **Effectiveness:** High. Establishing a new Medicare-certified home health agency directly expands capacity, improves care coordination, strengthens quality oversight, and supports continuity of care for patients served throughout the six-county region.

Conclusion

QOC considered multiple alternatives to address the identified need for expanded access to Medicare-certified home health services in the six-county region, including reliance on existing providers, contracted service delivery through existing agencies, and provision of limited non-Medicare services.

QOC selected the proposed project, establishment of a new Medicare-certified home health agency, because it offers the most effective and sustainable means of improving availability and accessibility of care, strengthening continuity of care, and maintaining high-quality service delivery at an appropriate cost over the life cycle of the project.

Accordingly, the proposed project satisfies the Alternatives to the Project Review Criterion under **COMAR 10.24.01.08G(3)(c)**.

10.24.01.08G(3)(d). Project Financial Feasibility and Facility or Program Viability Review Criterion.

The Commission shall consider the availability of resources necessary to implement the project and the availability of revenue sources and demand for the proposed services adequate to ensure ongoing viability and sustainability of the facility to be established or modified or the service to be introduced or expanded.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required (Tables H and I for all applicants and Table F for existing facilities and/or Table G, for new facilities, new services, and when requested by MHCC staff). Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the health care facility exists or is proposed, explain why the projected Medicare percentages are reasonable.
- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.
- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.
- Describe and document relevant community support for the proposed project.
- Identify the performance requirements applicable to the proposed project (see Part I question 15) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

APPLICANT RESPONSE- 10.24.01.08G(3)(d):

Quality One Care Home Health, Inc. (“QOC”) has developed a financially sustainable plan to establish and operate the proposed Medicare-certified Home Health Agency (“HHA”) serving the six-county region of Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties. The proposed project is supported by sufficient internal financial resources, conservative revenue assumptions, and staffing and expense projections consistent with comparable Maryland home health agency operations.

Project financial feasibility and long-term viability are demonstrated through the pro forma financial projections, staffing assumptions, and detailed line-item schedules included in **Exhibit 5 (Financial Tables and Statement of Assumptions)** and the CON Table Package, as well as the audited and or reviewed financial statements and supporting financial capacity documentation included in **Exhibit 6 (Financial Capacity Documentation, including CPA letters and financial statements)**.

1. Funding Plan and Financial Capacity

- **Sources of Funds:** The proposed project will be financed entirely through QOC’s available equity and operating reserves. QOC will maintain sufficient working capital to support start-up and ramp-up operations, including the period between initiation of services and stabilization of reimbursement cycles.
- **Availability of Financial Resources:** Audited and or reviewed financial statements for the past two years and supporting financial documentation are provided in **Exhibit 6**, demonstrating strong liquidity, stable cash flow, and the financial capacity to fund start-up and initial operating costs without external borrowing.
- **No Debt Financing, Grants, or Philanthropic Support Required:** QOC does not require debt financing, grant funding, fundraising, or philanthropic support to implement or sustain the proposed project. The project is financially feasible using internal resources documented in **Exhibit 6 – Financial Capacity Documentation**.

2. Sustainability of Revenue and Expense Projections

QOC’s financial projections in **Exhibit 5** and the CON Table Package are based on conservative assumptions and reflect standard Medicare-certified home health agency reimbursement and operating conditions. The projections incorporate:

- Payer mix assumptions consistent with MHCC jurisdiction-level home health utilization patterns in the six-county region

- Reimbursement assumptions consistent with Medicare home health payment methodologies and typical reimbursement timelines
- Conservative assumptions regarding productivity, staffing levels, benefits, clinical supplies, administrative overhead, and contracted resources.

QOC's projections demonstrate that the proposed agency will generate sufficient operating revenue to cover projected operating expenses and sustain ongoing operations as patient volume increases. The financial feasibility analysis considers both start-up costs and continuing operating costs over the initial three operating years and demonstrates viability throughout ramp-up.

3. Staffing Recruitment and Workforce Viability

QOC's staffing model supports projected utilization growth and includes adequate clinical and administrative capacity to provide timely service delivery and maintain compliance with Medicare Conditions of Participation. Staffing projections reflect:

- A phased hiring plan aligned with Year 1 through Year 3 utilization growth
- Competitive wage and benefit assumptions for nurses, therapists, and home health aides
- Administrative staffing sufficient to support billing, compliance oversight, quality reporting, and care coordination functions.

QOC has completed the Workforce and Bedside Care Staffing worksheets in the CON Table Package. Recruitment strategies will include targeted job postings, professional networks, workforce partnerships, and referral-based recruitment for experienced clinicians and support staff.

4. Alternative Financing Mechanisms Considered

In planning the proposed project, QOC evaluated potential financing mechanisms including debt financing and third-party capital support. QOC selected internal funding and working capital reserves as the preferred financing mechanism because it provides the lowest financial risk, avoids interest and repayment obligations, and ensures operational stability during the ramp-up period.

5. Demand, Referral Support, and Community Support

Demand for home health services in the six-county region is demonstrated by MHCC FY 2023 utilization data and the substantial volume of unduplicated clients and total visits documented in the need analysis. QOC's projected market penetration assumptions represent a modest share of existing utilization and reflect a conservative ramp-up trajectory.

QOC's established referral pathways and service linkages, documented in **Exhibit 17 (Linkages and Referral Pathways Plan)**, reflect relationships with hospitals, coordinating entities, schools, and community-based organizations that support service coordination and continuity of care. These linkages demonstrate market awareness of QOC's services and support the feasibility of the project's volume and revenue assumptions.

6. Ability to Meet Regulatory, Performance, and Operational Requirements Within Required Timeframes

QOC is prepared to complete all regulatory, licensure, and operational steps within the required timeframes, including:

- Medicare HHA enrollment and certification,
- State licensure approvals,
- implementation of required clinical and administrative systems and reporting processes, including OASIS and HHCAHPS participation, and
- establishment of payer contracting, billing, compliance, and quality monitoring systems.

QOC's operational readiness is supported by its existing organizational infrastructure, documented policies and procedures, and compliance experience, which collectively support the agency's ability to implement the project and sustain operations consistent with MHCC requirements.

7. Required Revenue and Expense Tables and Staffing Worksheets

QOC has completed the applicable Revenue and Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, including the required tables and any additional tables required for a new home health agency project. The assumptions supporting each revenue and expense line item are detailed in Exhibit 5 and the corresponding CON Table Package worksheets.

Conclusion

Based on the availability of financial resources documented in **Exhibit 6**, the conservative pro forma projections and assumptions documented in **Exhibit 5** and the CON Table Package, and the demonstrated demand for Medicare-certified home health services in the six-county region, QOC has the financial capacity to implement the proposed project and sustain ongoing operations. Accordingly, the proposed project satisfies the Project Financial Feasibility and Facility or Program Viability Review Criterion under **COMAR 10.24.01.08G(3)(d)**.

10.24.01.08G(3)(e). The “Compliance with Terms and Conditions of Previous Certificates of Need” Review Criterion. An applicant shall demonstrate compliance with all terms and conditions of each previous CON granted to the applicant.

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

APPLICANT RESPONSE- 10.24.01.08G(3)(e):

Quality One Care Home Health, Inc. (“QOC”), including its parent organization and any affiliates or subsidiaries, **has not been issued a Certificate of Need in Maryland within the past 15 years.** Accordingly, there are no prior Maryland Certificates of Need, terms, conditions, or approved changes applicable to QOC for which compliance must be demonstrated under **COMAR 10.24.01.08G(3)(e).**

10.24.01.08G(3)(f). Project Impact Review Criterion.
The Commission shall consider the impact of the proposed project on the costs and charges of existing providers of the facilities and services included in the project and on access to those facilities and services in the service area of the project.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

APPLICANT RESPONSE- 10.24.01.08G(3)(f):

Quality One Care Home Health, Inc. (“QOC”) evaluated the potential impact of the proposed Medicare-certified home health agency on existing providers and on access to services within the proposed six-county service area consisting of **Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties.** The impact analysis is based on MHCC FY 2023 home health utilization data and on QOC’s conservative volume projections and payer assumptions provided in **Exhibit 5 (Financial Tables and Statement of Assumptions).**

MHCC FY 2023 data demonstrate substantial baseline demand in the six-county region, including **51,258 unduplicated clients** (MHCC Table 17) and **779,489 total home health visits** (MHCC Table 19). QOC’s projected market penetration and ramp-up assumptions represent a modest share of existing utilization and are not based on displacement of incumbent agency caseloads. Accordingly, QOC

anticipates no material adverse impact on existing home health agencies and expects the proposed project to improve access to timely home health services and enhance provider choice across the service area.

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

APPLICANT RESPONSE - 10.24.01.08G(3)(f)(a):

QOC anticipates **no material negative impact** on the volume of services provided by existing Medicare-certified home health agencies operating in the six-county region. This conclusion is supported by the region's sustained baseline utilization and the conservative scale of QOC's projected volume relative to total regional utilization.

Key Assumptions and Supporting Information

1. **High baseline utilization.** MHCC FY 2023 data document **779,489 home health visits** in the six-county region and **51,258 unduplicated clients**, reflecting substantial ongoing demand (MHCC Tables 19 and 17).
2. **Conservative ramp-up and modest penetration.** QOC's projected volume increases gradually over Years 1 through 3 and represents a small share of total regional utilization, as documented in Exhibit 5.
3. **Targeted access expansion.** QOC will accept Medicare and Medicaid beneficiaries and will support referral sources that experience difficulty placing patients, including patients who require timely start-of-care, medically complex patients, and publicly insured beneficiaries. These admissions frequently represent unmet demand rather than a shift in existing provider utilization.

Based on MHCC regional utilization volumes and QOC's conservative projections, the proposed project is not expected to reduce service volumes or financial viability for incumbent agencies. Instead, QOC will add capacity to respond to sustained demand and support timely service delivery.

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

APPLICANT RESPONSE - 10.24.01.08G(3)(f)(b):

Impact on the Payer Mix of Existing Providers

QOC does not anticipate an adverse impact on the payer mix of other home health agencies in the six-county region. QOC's proposed payer acceptance policy is balanced and includes **Medicare (Traditional and Medicare Advantage), Medicaid (Traditional and Managed Care), Commercial Insurance, and other payer categories**, consistent with the regional payer composition observed in MHCC data.

Key Assumptions and Supporting Information

1. **Medicare-driven service demand.** MHCC FY 2023 data show that Medicare (Traditional and Medicare Advantage) represents the dominant payment source for home health services in each county in the six-county region (MHCC Table 17 and county-level payment source distribution tables).
2. **No selective targeting of commercially insured patients.** QOC will not limit admissions based on payer source and will fully participate in Medicaid programs consistent with licensing and certification requirements.
3. **Source of projected volume.** QOC's projected growth is expected to come primarily from new and unmet demand, including patients who experience delays or limited agency acceptance, rather than from targeted shifts of commercially insured patients away from incumbent agencies.

Accordingly, QOC's entry is not expected to cause a negative payer-mix shift among existing providers and is expected to improve access for Medicare and Medicaid beneficiaries without destabilizing incumbent agency payer distributions.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

APPLICANT RESPONSE - 10.24.01.08G(3)(f)(c):

Impact on Access to Health Care Services

The proposed project is expected to **improve access** to Medicare-certified home health services across the six-county region by increasing provider capacity, supporting timely admissions, and expanding service availability in jurisdictions with high utilization volumes as well as Southern Maryland counties where geographic distance and provider availability can affect start-of-care timeliness.

Access Improvements and Assumptions

1. **Reduced delays in initiation of care.** QOC will expand referral acceptance capacity and support timely admissions, particularly for patients who currently experience admission delays or limited provider acceptance.
2. **Expanded provider choice.** The proposed project will add a new Medicare-certified provider option across the six-county region, improving consumer choice and access to care coordination and clinical service continuity.
3. **Improved continuity of care across care transitions.** QOC's established linkages and referral pathways, including relationships with hospitals and coordinating entities documented in Exhibit 17, will support discharge planning, reduced care gaps, and improved transitions from acute and post-acute settings to home.

By adding an additional Medicare-certified home health agency platform serving all six counties, QOC will improve access for residents who require skilled home health services and support the State Health Plan objective of improving availability and accessibility of home health services.

d) On costs of the health care delivery system. If the applicant is an existing health care facility, provide a summary description of the impact of the proposed project on costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

APPLICANT RESPONSE - 10.24.01.08G(3)(f)(d):

QOC's proposed project is not expected to increase overall health system costs and may contribute to cost containment through improved access to timely home health services that support appropriate care in the home setting.

Cost Considerations and Supporting Information

1. **Avoided downstream utilization.** Improved access to timely home health services can reduce avoidable emergency department use, preventable readmissions, and institutional care costs by supporting adherence to care plans and monitoring during recovery.
2. **Expanded acceptance of publicly insured patients.** By increasing access for Medicare and Medicaid beneficiaries, the project may reduce reliance on higher-cost settings for care that can be appropriately delivered in the home.
3. **Efficient cost structure.** QOC's operating budget and staffing assumptions in Exhibit 5 reflect a sustainable cost structure with projected staffing levels and administrative overhead consistent with Medicare-certified home health agency operations.

Accordingly, QOC expects the proposed project to support system efficiency and cost-effective care delivery, consistent with State Health Plan objectives.

Conclusion

Based on MHCC FY 2023 utilization data demonstrating sustained demand in the six-county region (MHCC Tables 17 and 19) and QOC's conservative ramp-up assumptions documented in Exhibit 5, the proposed project is not expected to adversely affect existing providers. Instead, QOC's proposed Medicare-certified home health agency will expand provider capacity, improve access for Medicare and Medicaid beneficiaries, support timely initiation of care, and strengthen continuity of care across the service area. The project is also expected to support efficient care delivery and may contribute to reduced downstream health system costs by improving access to appropriate home-based services.

10.24.01.08G(3)(g) Health Equity. The Commission shall consider how a proposed project will address health care disparities in availability, accessibility, and quality of care among different populations within the service area. The Commission shall consider how social determinants of health within the service area of the proposed project create disparities in the delivery of health care.

INSTRUCTIONS: In evaluating proposed projects for health equity, the Commission will scrutinize the project's impact on health care disparities and social determinants within the service area. Health equity involves the fair distribution of resources and opportunities, ensuring individuals, regardless of background, have the chance to achieve their highest level of health. It further encompasses addressing disparities and systemic barriers that affect different populations.

With health equity in mind, the applicant shall identify the specific medically underserved area(s)/group(s)² within the designated service area and outline how the proposed project will address the unique health needs and quality of care for each identified group.

Applicants are expected to furnish a detailed overview of their organization's expertise and experience in health care access and service delivery. Emphasis should be placed on highlighting any relevant background that underscores the organization's commitment to equitable health care. This encompasses efforts to integrate implicit bias and cultural competency training within the health facility and among current staff members.

Please provide a comprehensive account of how the applicant planned with the community during the preparations for this project and how it will continue to engage with the community. Include a description of any specific initiatives and programs aimed at improving community well-being that are relevant to the proposed project. If applicable, the applicant should acknowledge any unintended barriers caused by the project that may have been identified through community discourse and propose proactive solutions to mitigate and rectify potential issues.

² According to HRSA, medically underserved populations and areas are identified as those which lack access to primary care services. These groups may face economic, cultural, or language barriers to health care. Some examples include People experiencing homelessness, people who are low-income, people who are eligible for Medicaid, Native Americans and other historically disadvantaged populations of color, migrant farm workers, etc.

(<https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups>)

APPLICANT RESPONSE - 10.24.01.08G(3)(g): HEALTH EQUITY

Quality One Care Home Health, Inc. (“QOC”) proposes to establish a Medicare-certified Home Health Agency (“HHA”) serving the six-county region of **Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties**. The proposed project is designed to address disparities in home health availability, accessibility, timeliness, and quality of care for medically underserved populations within the service area. QOC’s approach is informed by recognized social determinants of health (“SDOH”) that create barriers to receiving timely and effective home health services, including transportation limitations, language barriers, disability-related needs, housing instability, caregiver availability, and financial insecurity.

In evaluating health equity, QOC identified the medically underserved populations and communities within the six-county region that are most likely to experience barriers to home health access and continuity of care. QOC’s proposed HHA will implement targeted strategies to improve equitable access to skilled nursing, therapy, and aide services and to support safe care transitions and ongoing patient engagement for vulnerable populations.

1. Medically Underserved Populations and Communities in the Service Area

Consistent with HRSA’s definitions and examples of medically underserved areas and populations, QOC has identified the following groups within the six-county service area as likely to experience disparities in access to home health services:

- **Low-income residents**, including individuals who are uninsured or underinsured and those experiencing financial insecurity
- **Medicaid beneficiaries**, including individuals enrolled in Medicaid Managed Care
- **Dual-eligible beneficiaries** (Medicare and Medicaid)
- **Older adults**, particularly those with functional limitations, multiple chronic conditions, or limited caregiver support
- **Individuals with disabilities**, including individuals requiring mobility assistance or home safety supports
- **Residents with limited English proficiency**, including individuals who require interpretation or culturally responsive education
- **Racial and ethnic minority communities**, including communities experiencing higher chronic disease burden and reduced access to consistent outpatient care

- **Individuals experiencing housing instability or homelessness**, who may face challenges maintaining safe and continuous home-based care
- **Residents in rural and semi-rural areas of the service region**, where geographic distance and transportation constraints can delay initiation of services

These populations face higher risk of delayed access to home health services and disruptions in continuity of care due to Social Determinants of Health (SDOH) barriers that affect referral completion, timely initiation of care, and adherence to care plans.

2. How the Proposed Project Will Address Disparities in Availability, Accessibility, and Quality of Care

QOC's proposed HHA will address health care disparities and SDOH-related barriers through the following strategies:

A. Expanding access for publicly insured and underserved patients: QOC will accept Medicare and Medicaid beneficiaries, including patients with higher acuity and complex care needs, and will implement intake and scheduling workflows to support timely initiation of services. QOC's admission and payer acceptance approach is intended to reduce barriers that disproportionately affect Medicaid and dual-eligible patients.

B. Improving timely initiation of services and continuity of care: QOC will prioritize timely response to referrals and coordinate care transitions from hospitals, skilled nursing facilities, assisted living providers, and community-based organizations. QOC will support continuity of care through care coordination, patient education, and coordination with primary care and specialty providers.

C. Culturally responsive care and language access: QOC will provide culturally responsive services that support patients from diverse backgrounds. QOC will utilize interpretation services, bilingual staff when available, and patient education materials designed to support comprehension and adherence to care plans for patients and caregivers.

D. Addressing transportation and home safety barriers: QOC's care planning process will identify transportation limitations and home environment concerns that may affect treatment adherence, visit completion, and patient safety. When needed, QOC will provide referrals to community resources that support transportation access, home modifications, and safe home environments.

E. Supporting patients with complex medical and behavioral health needs: QOC will provide coordinated care planning for patients with chronic conditions, disability-related needs, and co-

occurring behavioral health challenges. QOC's model includes proactive communication with caregivers and referring providers to reduce preventable complications and escalation of care needs.

3. Organizational Expertise and Workforce Training to Promote Equity

QOC's organizational background includes more than a decade of experience delivering personal care and supportive services to medically fragile, low-income, and diverse populations as a licensed Residential Service Agency ("RSA"). This experience supports QOC's understanding of community needs and the operational requirements for delivering person-centered care to individuals with complex social and medical needs.

QOC will implement workforce training and competency expectations that support equitable service delivery, including training in:

- cultural humility and cultural responsiveness
- disability sensitivity and patient-centered communication
- trauma-informed communication and de-escalation approaches
- implicit bias awareness and equitable care practices
- language access procedures and effective patient education strategies

These training expectations will be incorporated into onboarding and annual training requirements and will be supported through QOC's quality monitoring and performance improvement activities. QOC's Health Equity and Cultural Competence planning documentation is included in **Exhibit 4B (Health Equity and Character and Competence Worksheet, COMAR cross-reference)**.

4. Community Planning and Ongoing Community Engagement

QOC's project planning incorporates engagement with referral sources and community partners that serve medically underserved populations, including hospitals, discharge planners, care coordination organizations, and community-based service organizations. QOC will continue engagement after implementation through structured collaboration with community stakeholders to improve referral efficiency, continuity of care, and care coordination.

- Ongoing engagement activities will include:
- periodic meetings with referral partners and care coordinators

- feedback processes for patients and caregivers regarding service access and satisfaction
- collaboration with community-based organizations to support patients with food insecurity, transportation barriers, and other SDOH needs
- review of patient access barriers and service delays through quality monitoring processes and corrective actions where needed

5. Identification of Potential Unintended Barriers and Mitigation Strategies

QOC recognizes that unintended barriers may arise during implementation, including barriers related to workforce availability, geographic travel time in rural areas, language access needs, and referral complexity for high-acuity patients. QOC will mitigate these potential barriers through:

- phased staffing growth aligned with projected volume
- service area scheduling strategies that support efficient travel and timely admissions
- continued use of interpreter services and culturally responsive education tools
- quality monitoring of referral acceptance rates, timeliness of start of care, and patient experience across demographic groups

If disparities or access concerns are identified through community feedback or performance monitoring, QOC will implement timely adjustments to policies, staffing plans, referral workflows, and quality improvement strategies to support equitable access to care throughout the service area.

Conclusion

Through targeted strategies to expand access, address SDOH-related barriers, support culturally responsive care delivery, and sustain ongoing community engagement, QOC's proposed Medicare-certified home health agency will address health care disparities in availability, accessibility, and quality of care within the six-county service area.

QOC's experience serving vulnerable populations and its planned workforce training and quality monitoring systems will support equitable service delivery consistent with **COMAR 10.24.01.08G(3)(g)**.

10.24.01.08G(3)(h) Character and Competence. The Commission shall assess the character and competence of an applicant based upon experience and past performance, including any records of violation in operating a health care service or facility.

INSTRUCTIONS: In evaluating proposed projects for Character/Competence, the Commission will review the information provided in response to Part III of the application and look for a detailed narrative response highlighting any past issues and how any issues have now been corrected or addressed. If there have not been any past issues please include in your narrative any history that has been a positive reflection of character/competence. The response should include, at minimum:

- names/addresses of all owners and individuals responsible for the proposed project and its implementation. This includes any person with 5% or more ownership interest in the real property, bed rights or operations of the facility
- for each individual identified disclose any involvement in the ownership, development, or management of another health care facility
- for each individual and facility identified disclose if any license has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years
- for each individual and facility identified disclose inquiries in the last from 10 years from any federal (CMS) or state authority (OHCQ), or other regulatory body regarding possible non-compliance with any state, or federal requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions
- disclose if any owners and individuals responsible for the project have identified above have ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities

REMEMBER TO SUBMIT THE COMPANION TABLE SET FEATURING THE PROJECT BUDGET, STATISTICAL PROJECTIONS, REVENUE AND EXPENSE PROJECTIONS, AND WORKFORCE INFORMATION

APPLICANT RESPONSE - 10.24.01.08G(3)(h):

CHARACTER AND COMPETENCE

Quality One Care Home Health, Inc. ("QOC") affirms that the individuals responsible for the ownership, governance, management, and implementation of the proposed Medicare-certified Home Health Agency demonstrate the character and competence necessary to establish and operate a licensed and certified health care provider in Maryland. This response is consistent with the disclosures provided in **Part III of the CON application.**

1. Owners and Individuals Responsible for the Proposed Project (Names and Addresses)

The individual with ownership interests and responsibility for the proposed project, including any person with five percent or greater ownership interest in the applicant entity, are listed below:

Individual	Role in Applicant / Proposed Project	Ownership Interest	Business Address
Mohamed Matope	Owner & Director	100%	9221 Colesville Road Silver Spring, MD 20910

This individual will be responsible for the planning, implementation, and oversight of the proposed home health agency, including regulatory compliance, financial stewardship, clinical operations, and quality assurance.

2. Prior Involvement in Ownership, Development, or Management of Health Care Facilities

As disclosed in Part III, the individual identified above has not been involved in the ownership, development, or management of a health care facility with a record of violations or compliance problems.

3. License Actions or Disciplinary Actions in the Past Five Years

Neither QOC nor the individual identified above has had any license suspended, revoked, surrendered, restricted, or otherwise subject to disciplinary action in the past five years related to the ownership, development, or management of a health care facility. QOC has not been subject to admissions bans, probationary status, corrective action mandates, or quality-of-care sanctions.

4. Regulatory Inquiries or Enforcement Actions in the Past Ten Years

Neither QOC nor the individual identified above has been subject to inquiries, audits, enforcement actions, or adverse findings within the past ten years by the Centers for Medicare and Medicaid Services ("CMS"), the Maryland Office of Health Care Quality ("OHCQ"), or any other regulatory authority related to noncompliance with federal or State requirements governing quality of care or payment for health care services that resulted in penalties, admissions bans, probationary status, or other sanctions.

5. Criminal Offense History Related to Health Care Ownership or Management

Neither QOC nor the individual identified above has pled guilty to or been convicted of a criminal offense connected to the ownership, development, or management of a health care entity, including

offenses involving fraud, abuse, neglect, or quality-of-care violations.

6. Positive Compliance History and Operational Competence

QOC has operated licensed health-related services in Maryland and maintains policies and procedures supporting ethical operations, regulatory compliance, staff training, and quality oversight. QOC's operational practices emphasize timely reporting, licensure and renewal compliance, patient safety, staff competency, and adherence to applicable State and federal requirements.

Conclusion

Based on the disclosures provided in Part III and the affirmations summarized above, QOC demonstrates the character, competence, and regulatory integrity necessary to establish and operate the proposed Medicare-certified home health agency in accordance with COMAR 10.24.01.08G(3)(h).

**PART III - APPLICANT HISTORY, STATEMENT
OF RESPONSIBILITY, AUTHORIZATION AND
SIGNATURE**

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identify and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

Mohamed Matope

9221 Colesville Road

Silver Spring, MD 20910

2. Is the applicant, or any person listed above now involved, or has ever been involved, in the ownership, development, or management of another health care facility or program? If yes, provide a listing of each facility or program, including facility name, address, and dates of involvement.

NO

3. Has the Maryland license or certification of the applicant home health agency, or any of the facilities or programs listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner, or other person responsible for implementation of the Project was not involved with the facility or program at the time a suspension, revocation, or disciplinary action took place, indicated in the explanation.

NO

1. Is any facility or program with which the applicant is involved, or has any facility or program with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility or program. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility or program, and any final disposition reached by the applicable governmental authority.

NO

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or

management of the applicant facility or program or any health care facility or program listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

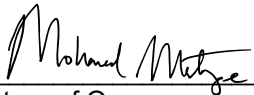
NO

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed home healthy agency service.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

JAN 09, 2025

Date



Signature of Owner or
Authorized Agent of the Applicant

**Part IV: Home Health Agency Application:
Charts and Tables Supplement**

Part IV: Home Health Agency Application: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET

TABLE 2A: STATISTICAL PROJECTIONS – FOR HHA SERVICES IN MARYLAND

TABLE 2B: STATISTICAL PROJECTIONS – FOR PROPOSED JURISDICTIONS

TABLE 3: REVENUES AND EXPENSES - FOR HHA SERVICES IN MARYLAND

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

TABLE 5: STAFFING INFORMATION

TABLE 1: PROJECT BUDGET

Instructions: All estimates for 1a- d; 2a- f; and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. Inflation from date of submission of project completion should only be included on the Inflation line 1e. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. USE OF FUNDS	
1. CAPITAL COSTS (if applicable):	
a. New Construction	
1) Building	0
2) Fixed Equipment (not included in construction)	0
3) Architect/Engineering Fees	0
4) Permits, (Building, Utilities, Etc.)	0
a. SUBTOTAL New Construction	0
b. Renovations	
1) Building	0
2) Fixed Equipment (not included in construction)	0
3) Architect/Engineering Fees	0
4) Permits, (Building, Utilities, Etc.)	0
b. SUBTOTAL Renovations	0
c. Other Capital Costs	
1) Movable Equipment	0
2) Contingency Allowance	0
3) Gross Interest During Construction	0
4) Other	0
c. SUBTOTAL Other Capital Cost	0
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	0
Non-Current Capital Cost	
d. Land Purchase Cost or Value of Donated Land	0
e. Inflation (state all assumptions, including time period and rate)	0
TOTAL PROPOSED CAPITAL COSTS (sum of a - e)	0
2. FINANCING COST AND OTHER CASH REQUIREMENTS	
a. Loan Placement Fees	0
b. Bond Discount	0
c. CON Application Assistance	0
c1. Legal Fees	0
c2 Other (Specify and add lines as needed)	0
d. Non-CON Consulting Fees	0
d1. Legal Fees	0
d2. Other	0
e. Debt Service Reserve Fund	0
f. Other (Specify)	0
TOTAL (a - e)	0
3. WORKING CAPITAL STARTUP COSTS	
TOTAL USES OF FUNDS (sum of 1 - 3)	0

B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	0
2. Pledges: Gross _____, less allowance for uncollectable _____ = Net	0
3. Gifts, bequests	0
4. Authorized Bonds	0
5. Interest income (gross)	0
6. Mortgage	0
7. Working capital loans	0
8. Grants or Appropriation	
a. Federal	0
b. State	0
c. Local	0
9. Other (Specify)	0
TOTAL SOURCES OF FUNDS (sum of 1-9)	0
ANNUAL LEASE COSTS (if applicable)	
• Land	0
• Building	0
• Moveable equipment	0
• Other (specify)	0

APPLICANTS RESPONSE – TABLE 1: PROJECT BUDGET

This table is not applicable because the proposed project does not involve any new construction, renovations, land acquisition, or other capital expenditures. QOC will operate as an office-based Medicare-certified home health agency using existing administrative space and standard non-capital equipment; therefore, total project capital costs and financing costs are \$0. Operating revenue and expense projections are provided in **Exhibit 5 – Financial Tables and Statement of Assumptions**.

QOC will establish a leased administrative suboffice space in Southern Maryland (Calvert, Charles, and St. Mary’s Counties); however, any lease and routine office setup costs are treated as operating expenses and are reflected in **Exhibit 5**, not capital project costs.

TABLE 2A: STATISTICAL PROJECTIONS – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND

Instructions: Table 2A applies to an applicant that is an existing home health agency and should be completed showing historic and projected utilization *for all home health agency services provided in Maryland.*

Table should report an *unduplicated count of clients* and should indicate whether the reporting period is Calendar Year (CY) or Fiscal Year (FY).

APPLICANT RESPONSE – TABLE 2A: STATISTICAL PROJECTIONS

Not Applicable – Quality One Care Home Health, Inc. is applying as a new Medicare-certified Home Health Agency and does not have historical utilization data. Therefore, Table 2A does not apply.

	Two Most Current Actual Years		Projected years – ending with first year at full utilization			
			20	20	20	20
CY or FY (circle)						
Client Visits						
Billable						
Non-Billable						
TOTAL						
# of Clients and Visits by Discipline						
Total Clients (Unduplicated Count)						
Skilled Nursing Visits						
Home Health Aide Visits						
Physical Therapy Visits						
Occupational Therapy Visits						
Speech Therapy Visits						
Medical Social Services Visits						
Other Visits (Please Specify)						

TABLE 2B: STATISTICAL PROJECTIONS - PROJECTED HOME HEALTH AGENCY SERVICES IN THE PROPOSED PROJECT

Instructions: All applicants should complete Table 2B for the proposed project, showing projected utilization *only for the jurisdiction(s) which is the subject of the application*. As in Table 2A above, this table should report an unduplicated count of clients, and should indicate whether the reporting period is Calendar Year (CY) or Fiscal Year (FY).

APPLICANT RESPONSE – TABLE 2B-1: ANNE ARUNDEL COUNTY

1. ANNE ARUNDEL COUNTY PROJECTIONS

	Projected years – ending with first year at full utilization			
FY	2026	2027	2028	20__
Client Visits				
Billable	441	867	1294	
Non-Billable	9	18	26	
TOTAL	450	885	1320	
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	30	59	87	
Skilled Nursing Visits	158	310	462	
Home Health Aide Visits	180	354	529	
Physical Therapy Visits	54	106	158	
Occupational Therapy Visits	27	53	79	
Speech Therapy Visits	9	18	26	
Medical Social Services Visits	22	44	66	
Other Visits (Please Specify)				

* Unduplicated client counts were estimated by dividing projected total visits by the MHCC FY 2023 six-county average visits per home health client (15.21 visits per client), derived from MHCC Table 19 (Total Visits) and Table 17 (Total Clients).

2026: $450 \div 15.21 = 29.6 \rightarrow 30$

2027: $885 \div 15.21 = 58.2 \rightarrow 59$

2028: $1320 \div 15.21 = 86.8 \rightarrow 87$

* This approach ensures projected unduplicated client volumes are consistent with observed utilization intensity across the six-county review area.

APPLICANT RESPONSE – TABLE 2B-2: MONTGOMERY COUNTY

2. MONTGOMERY COUNTY PROJECTIONS

	Projected years – ending with first year at full utilization			
FY	2026	2027	2028	20__
Client Visits				
Billable	720	1441	2161	
Non-Billable	15	29	44	
TOTAL	735	1470	2205	
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	48	97	145	
Skilled Nursing Visits	257	514	772	
Home Health Aide Visits	294	588	882	
Physical Therapy Visits	88	176	265	
Occupational Therapy Visits	44	88	132	
Speech Therapy Visits	15	29	44	
Medical Social Services Visits	37	74	110	
Other Visits (Please Specify)				

* Unduplicated client counts were estimated by dividing projected total visits by the MHCC FY 2023 six-county average visits per home health client (15.21 visits per client), derived from MHCC Table 19 (Total Visits) and Table 17 (Total Clients).

2026: $735 \div 15.21 = 48.3 \rightarrow 48$

2027: $1470 \div 15.21 = 96.6 \rightarrow 97$

2028: $2205 \div 15.21 = 145.0 \rightarrow 145$

* This approach ensures projected unduplicated client volumes are consistent with observed utilization intensity across the six-county review area.

APPLICANT RESPONSE – TABLE 2B-3: PRINCE GEORGE’S COUNTY

3. PRINCE GEORGE’S COUNTY PROJECTIONS

	Projected years – ending with first year at full utilization			
FY	2026	2027	2028	20__
Client Visits				
Billable	544	1073	1617	
Non-Billable	11	22	33	
TOTAL	555	1095	1650	
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	37	72	109	
Skilled Nursing Visits	194	383	578	
Home Health Aide Visits	222	438	660	
Physical Therapy Visits	67	131	198	
Occupational Therapy Visits	33	66	99	
Speech Therapy Visits	11	22	33	
Medical Social Services Visits	28	55	82	
Other Visits (Please Specify)				

* Unduplicated client counts were estimated by dividing projected total visits by the MHCC FY 2023 six-county average visits per home health client (15.21 visits per client), derived from MHCC Table 19 (Total Visits) and Table 17 (Total Clients).

$$\mathbf{2026: 555 \div 15.21 = 36.5 \rightarrow 37}$$

$$\mathbf{2027: 1095 \div 15.21 = 72.0 \rightarrow 72}$$

$$\mathbf{2028: 1650 \div 15.21 = 108.5 \rightarrow 109}$$

* This approach ensures projected unduplicated client volumes are consistent with observed utilization intensity across the six-county review area.

APPLICANT RESPONSE – TABLE 2B-4: CALVERT COUNTY

4. CALVERT COUNTY PROJECTIONS

FY	Projected years – ending with first year at full utilization			
	2026	2027	2028	20__
Client Visits				
Billable	147	294	441	
Non-Billable	3	6	9	
TOTAL	150	300	450	
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	10	20	30	
Skilled Nursing Visits	52	105	158	
Home Health Aide Visits	60	120	180	
Physical Therapy Visits	18	36	54	
Occupational Therapy Visits	9	18	27	
Speech Therapy Visits	3	6	9	
Medical Social Services Visits	8	15	22	
Other Visits (Please Specify)				

* Unduplicated client counts were estimated by dividing projected total visits by the MHCC FY 2023 six-county average visits per home health client (15.21 visits per client), derived from MHCC Table 19 (Total Visits) and Table 17 (Total Clients).

2026: $150 \div 15.21 = 9.9 \rightarrow 10$

2027: $300 \div 15.21 = 19.7 \rightarrow 20$

2028: $450 \div 15.21 = 29.6 \rightarrow 30$

* This approach ensures projected unduplicated client volumes are consistent with observed utilization intensity across the six-county review area.

APPLICANT RESPONSE – TABLE 2B-5: CHARLES COUNTY

5. CHARLES COUNTY PROJECTIONS

	Projected years – ending with first year at full utilization			
FY	2026	2027	2028	20__
Client Visits				
Billable	250	514	764	
Non-Billable	5	11	16	
TOTAL	255	525	780	
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	17	35	51	
Skilled Nursing Visits	89	184	273	
Home Health Aide Visits	102	210	312	
Physical Therapy Visits	31	63	94	
Occupational Therapy Visits	15	32	47	
Speech Therapy Visits	5	10	16	
Medical Social Services Visits	13	26	39	
Other Visits (Please Specify)				

* Unduplicated client counts were estimated by dividing projected total visits by the MHCC FY 2023 six-county average visits per home health client (15.21 visits per client), derived from MHCC Table 19 (Total Visits) and Table 17 (Total Clients).

2026: $255 \div 15.21 = 16.8 \rightarrow 17$

2027: $525 \div 15.21 = 34.5 \rightarrow 35$

2028: $780 \div 15.21 = 51.3 \rightarrow 51$

* This approach ensures projected unduplicated client volumes are consistent with observed utilization intensity across the six-county review area.

APPLICANT RESPONSE – TABLE 2B-6: ST MARY’S COUNTY

6. ST MARY’S COUNTY PROJECTIONS

FY	Projected years – ending with first year at full utilization			
	2026	2027	2028	20__
Client Visits				
Billable	176	353	529	
Non-Billable	4	7	11	
TOTAL	180	360	540	
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	12	24	36	
Skilled Nursing Visits	63	126	189	
Home Health Aide Visits	71	144	216	
Physical Therapy Visits	22	43	65	
Occupational Therapy Visits	11	22	32	
Speech Therapy Visits	4	7	11	
Medical Social Services Visits	9	18	27	
Other Visits (Please Specify)				

* Unduplicated client counts were estimated by dividing projected total visits by the MHCC FY 2023 six-county average visits per home health client (15.21 visits per client), derived from MHCC Table 19 (Total Visits) and Table 17 (Total Clients).

2026: $180 \div 15.21 = 11.8 \rightarrow 12$

2027: $360 \div 15.21 = 23.7 \rightarrow 24$

2028: $540 \div 15.21 = 35.5 \rightarrow 36$

* This approach ensures projected unduplicated client volumes are consistent with observed utilization intensity across the six-county review area.

Table 2B Statistical Projections – Assumptions (Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, St. Mary’s County)

Projections reflect a conservative start-up ramp and are intended to be consistent with publicly reported county-level home health utilization patterns.

Baseline Utilization Reference

County-level home health utilization (unduplicated clients and total visits) was referenced from MHCC FY23 utilization tables to inform relative scale across jurisdictions and to support conservative market-entry assumptions.

Market Penetration (Unduplicated Clients)

- Larger jurisdictions (Anne Arundel, Montgomery, Prince George’s): initial penetration assumed at approximately 0.25% of FY23 county clients in the first full operating year, increasing to ~0.50% in Year 2 and ~0.75% in Year 3.
- Smaller jurisdictions (Calvert, Charles, St. Mary’s): initial penetration assumed at approximately 0.75% of FY23 county clients in Year 1, increasing to ~1.50% in Year 2 and ~2.25% in Year 3.
- These assumptions reflect typical start-up constraints (credentialing and referral development) and gradual build to stable referral sources.

Visits per Client

- Average visits per client were assumed at **15.21 visits per client per year**, derived from MHCC FY 2023 utilization (Table 19 Total Visits ÷ Table 17 Total Clients), and applied consistently across jurisdictions.
- Total projected visits = projected unduplicated clients × 15.21 visits/client/year.

Billable vs. Non-Billable Visits

- Billable visits were assumed at 98% of total visits; non-billable visits were assumed at 2% of total visits.
- Non-billable visits include start-up inefficiencies, patient no-shows, documentation/training time, and other non-covered activities.

Discipline Mix

Projected visits were allocated across disciplines using a standard start-up home health mix:

- Skilled Nursing (SN): 35%
- Home Health Aide (HHA): 40%
- Physical Therapy (PT): 12%
- Occupational Therapy (OT): 6%
- Speech Pathology: 2%
- Medical Social Services (MSS): 5%

The mix may shift modestly over time based on payer mix, referral patterns, and patient acuity, but is intended to reflect a balanced service model at start-up.

Implementation Notes

Projected volumes are designed to be achievable given start-up staffing and referral development timelines and are expected to be supported by incremental staffing increases shown in Table 5.

Projections are conservative and do not assume rapid displacement of existing providers or immediate high-volume capture in any single jurisdiction.

TABLE 3: REVENUES AND EXPENSES – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND (including proposed project)

Instructions: an existing home health agency must complete Table 3, showing historic and projected revenues and expenses for all home health agency services provided *in Maryland*.

Projections should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application.

Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY).

APPLICANT RESPONSE: TABLE 3 – REVENUES AND EXPENSES

Not Applicable – Quality One Care Home Health, Inc. is applying as a new Medicare-certified Home Health Agency and does not have historical utilization data.

	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__	20__	20__	20__	20__	20__
CY or FY (Circle)							
1. Revenue							
Gross Patient Service Revenue							
Allowance for Bad Debt							
Contractual Allowance							
Charity Care							
Net Patient Services Revenue							
Other Operating Revenues (Specify)							
Net Operating Revenue							
2. Expenses							
Salaries, Wages, and Professional							

Fees, (including fringe benefits)							
Contractual Services (please specify)							
Interest on Current Debt							
Interest on Project Debt							
Current Depreciation							
Project Depreciation							
Current Amortization							
Project Amortization							
Supplies							
Other Expenses (Specify)							
Total Operating Expenses							
3. Income							
Income from Operation							
Non- Operating Income							
Subtotal							
Income Taxes							
Net Income (Loss)							
Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__

4A. - Payor Mix as Percent of Total Revenue

Medicare							
Medicare Advantage							
Medicaid							
Medicaid MCO							
Blue Cross							
Commercial Insurance							
Self-Pay							
Other (Specify)							
TOTAL REVENUE	100%	100%	100%	100%	100%	100%	100%
4B. Payor Mix as Percent of Total Visits							
Medicare							
Medicare Advantage							
Medicaid							
Medicaid MCO							
Blue Cross							
Other Commercial Insurance							
Self-Pay							
Other (Specify)							
TOTAL VISITS	100%	100%	100%	100%	100%	100%	100%

NOTE: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS.

TABLE 4: REVENUES AND EXPENSES – PROJECTED HOME HEALTH AGENCY SERVICES FOR PROPOSED PROJECT

TABLE 4: REVENUES AND EXPENSES – PROPOSED PROJECT (v5B – Charity Care Presented as Positive Amount)

Charity Care is shown as a positive amount (≥0.2% of Gross Patient Service Revenue) consistent with MHCC review expectations; Net Patient Services Revenue is calculated net of Charity Care, Contractual Allowance, and Bad Debt.

Anne Arundel County

Line Item	2026	2027	2028
Gross Patient Service Revenue	\$94,775	\$185,855	\$276,408
Allowance for Bad Debt (1%)	\$948	\$1,859	\$2,764
Contractual Allowance (8%)	\$7,582	\$14,868	\$22,113
Charity Care (≥0.2% of Gross Revenue; MHCC benchmark commitment)	\$190	\$372	\$553
Net Patient Services Revenue	\$86,056	\$168,756	\$250,978
Other Operating Revenues (Specify)	\$0	\$0	\$0
Net Operating Revenue	\$86,056	\$168,756	\$250,978
Salaries, Wages, and Professional Fees (incl. fringe benefits)	\$30,150	\$59,295	\$88,440
Contractual Services (PT/OT/SLP)	\$13,950	\$27,435	\$40,920
Supplies	\$1,350	\$2,655	\$3,960
Other Expenses (medical supplies, mileage, admin, etc.)	\$40,629	\$62,520	\$77,159
Total Operating Expenses	\$86,079	\$151,905	\$210,479
Income from Operation	\$-23	\$16,851	\$40,500
Non-Operating Income	\$0	\$0	\$0
Subtotal	\$-23	\$16,851	\$40,500
Income Taxes	\$0	\$0	\$0
Net Income (Loss)	\$-23	\$16,851	\$40,500

Montgomery County

Line Item	2026	2027	2028
Gross Patient Service Revenue	\$152,836	\$304,782	\$455,838
Allowance for Bad Debt (1%)	\$1,528	\$3,048	\$4,558
Contractual Allowance (8%)	\$12,227	\$24,383	\$36,467
Charity Care (≥0.2% of Gross Revenue; MHCC benchmark commitment)	\$306	\$610	\$912
Net Patient Services Revenue	\$138,775	\$276,742	\$413,901
Other Operating Revenues (Specify)	\$0	\$0	\$0
Net Operating Revenue	\$138,775	\$276,742	\$413,901
Salaries, Wages, and Professional Fees (incl. fringe benefits)	\$49,245	\$98,490	\$147,735
Contractual Services (PT/OT/SLP)	\$22,785	\$45,570	\$68,355
Supplies	\$2,205	\$4,410	\$6,615
Other Expenses (medical supplies, mileage, admin, etc.)	\$66,360	\$103,847	\$128,890
Total Operating Expenses	\$140,595	\$252,317	\$351,595
Income from Operation	\$-1,820	\$24,425	\$62,306
Non-Operating Income	\$0	\$0	\$0
Subtotal	\$-1,820	\$24,425	\$62,306
Income Taxes	\$0	\$0	\$0
Net Income (Loss)	\$-1,820	\$24,425	\$62,306

Prince George's County

Line Item	2026	2027	2028
Gross Patient Service Revenue	\$115,407	\$227,032	\$341,103
Allowance for Bad Debt (1%)	\$1,154	\$2,270	\$3,411
Contractual Allowance (8%)	\$9,233	\$18,163	\$27,288
Charity Care (≥0.2% of Gross Revenue; MHCC benchmark commitment)	\$231	\$454	\$682
Net Patient Services Revenue	\$104,790	\$206,145	\$309,722
Other Operating Revenues (Specify)	\$0	\$0	\$0
Net Operating Revenue	\$104,790	\$206,145	\$309,722
Salaries, Wages, and Professional Fees (incl. fringe benefits)	\$37,185	\$73,365	\$110,550
Contractual Services (PT/OT/SLP)	\$17,205	\$33,945	\$51,150
Supplies	\$1,665	\$3,285	\$4,950
Other Expenses (medical supplies, mileage, admin, etc.)	\$50,109	\$77,356	\$96,448
Total Operating Expenses	\$106,164	\$187,951	\$263,098
Income from Operation	\$-1,374	\$18,194	\$46,623
Non-Operating Income	\$0	\$0	\$0
Subtotal	\$-1,374	\$18,194	\$46,623
Income Taxes	\$0	\$0	\$0
Net Income (Loss)	\$-1,374	\$18,194	\$46,623

Calvert County

Line Item	2026	2027	2028
Gross Patient Service Revenue	\$31,280	\$62,379	\$93,296
Allowance for Bad Debt (1%)	\$313	\$624	\$933
Contractual Allowance (8%)	\$2,502	\$4,990	\$7,464
Charity Care (≥0.2% of Gross Revenue; MHCC benchmark commitment)	\$63	\$125	\$187
Net Patient Services Revenue	\$28,402	\$56,640	\$84,713
Other Operating Revenues (Specify)	\$0	\$0	\$0
Net Operating Revenue	\$28,402	\$56,640	\$84,713
Salaries, Wages, and Professional Fees (incl. fringe benefits)	\$10,050	\$20,100	\$30,150
Contractual Services (PT/OT/SLP)	\$4,650	\$9,300	\$13,950
Supplies	\$450	\$900	\$1,350
Other Expenses (medical supplies, mileage, admin, etc.)	\$13,543	\$21,193	\$26,304
Total Operating Expenses	\$28,693	\$51,493	\$71,754
Income from Operation	\$-290	\$5,147	\$12,958
Non-Operating Income	\$0	\$0	\$0
Subtotal	\$-290	\$5,147	\$12,958
Income Taxes	\$0	\$0	\$0
Net Income (Loss)	\$-290	\$5,147	\$12,958

Charles County

Line Item	2026	2027	2028
Gross Patient Service Revenue	\$53,176	\$109,163	\$161,713
Allowance for Bad Debt (1%)	\$532	\$1,092	\$1,617
Contractual Allowance (8%)	\$4,254	\$8,733	\$12,937
Charity Care (≥0.2% of Gross Revenue; MHCC benchmark commitment)	\$106	\$218	\$323
Net Patient Services Revenue	\$48,284	\$99,120	\$146,835
Other Operating Revenues (Specify)	\$0	\$0	\$0
Net Operating Revenue	\$48,284	\$99,120	\$146,835
Salaries, Wages, and Professional Fees (incl. fringe benefits)	\$17,085	\$35,175	\$52,260
Contractual Services (PT/OT/SLP)	\$7,905	\$16,275	\$24,180
Supplies	\$765	\$1,575	\$2,340
Other Expenses (medical supplies, mileage, admin, etc.)	\$23,023	\$37,088	\$45,594
Total Operating Expenses	\$48,778	\$90,113	\$124,374
Income from Operation	\$-494	\$9,007	\$22,461
Non-Operating Income	\$0	\$0	\$0
Subtotal	\$-494	\$9,007	\$22,461
Income Taxes	\$0	\$0	\$0
Net Income (Loss)	\$-494	\$9,007	\$22,461

St. Mary's County

Line Item	2026	2027	2028
Gross Patient Service Revenue	\$37,536	\$74,855	\$111,955
Allowance for Bad Debt (1%)	\$375	\$749	\$1,120
Contractual Allowance (8%)	\$3,003	\$5,988	\$8,956
Charity Care (≥0.2% of Gross Revenue; MHCC benchmark commitment)	\$75	\$150	\$224
Net Patient Services Revenue	\$34,083	\$67,968	\$101,655
Other Operating Revenues (Specify)	\$0	\$0	\$0
Net Operating Revenue	\$34,083	\$67,968	\$101,655
Salaries, Wages, and Professional Fees (incl. fringe benefits)	\$12,060	\$24,120	\$36,180
Contractual Services (PT/OT/SLP)	\$5,580	\$11,160	\$16,740
Supplies	\$540	\$1,080	\$1,620
Other Expenses (medical supplies, mileage, admin, etc.)	\$16,251	\$25,432	\$31,565
Total Operating Expenses	\$34,431	\$61,792	\$86,105
Income from Operation	\$-348	\$6,176	\$15,550
Non-Operating Income	\$0	\$0	\$0
Subtotal	\$-348	\$6,176	\$15,550
Income Taxes	\$0	\$0	\$0
Net Income (Loss)	\$-348	\$6,176	\$15,550

TABLE 4 CONT. – PAYER MIX (BY COUNTY)

4A: Payer Mix as Percent of Total Revenue; 4B: Payer Mix as Percent of Total Visits.

Anne Arundel County – Payer Mix

Payer	2026	2027	2028
Medicare	76.56% (rev) / 73.20% (visits)	73.63% (rev) / 70.20% (visits)	70.69% (rev) / 67.20% (visits)
MA	11.61% (rev) / 12.00% (visits)	13.58% (rev) / 14.00% (visits)	15.57% (rev) / 16.00% (visits)
Medicaid	0.58% (rev) / 1.70% (visits)	0.58% (rev) / 1.70% (visits)	0.58% (rev) / 1.70% (visits)
Commercial	9.15% (rev) / 10.00% (visits)	10.10% (rev) / 11.00% (visits)	11.04% (rev) / 12.00% (visits)
Other	2.11% (rev) / 3.10% (visits)	2.11% (rev) / 3.10% (visits)	2.12% (rev) / 3.10% (visits)

Montgomery County – Payer Mix

Payer	2026	2027	2028
Medicare	66.10% (rev) / 62.40% (visits)	63.10% (rev) / 59.40% (visits)	60.09% (rev) / 56.40% (visits)
MA	21.65% (rev) / 22.10% (visits)	23.68% (rev) / 24.10% (visits)	25.72% (rev) / 26.10% (visits)
Medicaid	1.00% (rev) / 2.90% (visits)	1.00% (rev) / 2.90% (visits)	1.00% (rev) / 2.90% (visits)
Commercial	10.01% (rev) / 10.80% (visits)	10.97% (rev) / 11.80% (visits)	11.93% (rev) / 12.80% (visits)
Other	1.24% (rev) / 1.80% (visits)	1.24% (rev) / 1.80% (visits)	1.25% (rev) / 1.80% (visits)

Prince George's County – Payer Mix

Payer	2026	2027	2028
Medicare	66.10% (rev) / 62.40% (visits)	63.10% (rev) / 59.40% (visits)	60.09% (rev) / 56.40% (visits)
MA	21.65% (rev) / 22.10% (visits)	23.68% (rev) / 24.10% (visits)	25.72% (rev) / 26.10% (visits)
Medicaid	1.00% (rev) / 2.90% (visits)	1.00% (rev) / 2.90% (visits)	1.00% (rev) / 2.90% (visits)
Commercial	10.01% (rev) / 10.80% (visits)	10.97% (rev) / 11.80% (visits)	11.93% (rev) / 12.80% (visits)
Other	1.24% (rev) / 1.80% (visits)	1.24% (rev) / 1.80% (visits)	1.25% (rev) / 1.80% (visits)

Calvert County – Payer Mix

Payer	2026	2027	2028
Medicare	78.48% (rev) / 74.30% (visits)	75.53% (rev) / 71.30% (visits)	72.56% (rev) / 68.30% (visits)
MA	8.70% (rev) / 8.90% (visits)	10.68% (rev) / 10.90% (visits)	12.68% (rev) / 12.90% (visits)
Medicaid	1.44% (rev) / 4.20% (visits)	1.45% (rev) / 4.20% (visits)	1.45% (rev) / 4.20% (visits)
Commercial	10.63% (rev) / 11.50% (visits)	11.59% (rev) / 12.50% (visits)	12.55% (rev) / 13.50% (visits)
Other	0.76% (rev) / 1.10% (visits)	0.76% (rev) / 1.10% (visits)	0.76% (rev) / 1.10% (visits)

Charles County – Payer Mix

Payer	2026	2027	2028
Medicare	78.48% (rev) / 74.30% (visits)	75.53% (rev) / 71.30% (visits)	72.56% (rev) / 68.30% (visits)
MA	8.70% (rev) / 8.90% (visits)	10.68% (rev) / 10.90% (visits)	12.68% (rev) / 12.90% (visits)
Medicaid	1.44% (rev) / 4.20% (visits)	1.45% (rev) / 4.20% (visits)	1.45% (rev) / 4.20% (visits)
Commercial	10.63% (rev) / 11.50% (visits)	11.59% (rev) / 12.50% (visits)	12.55% (rev) / 13.50% (visits)
Other	0.76% (rev) / 1.10% (visits)	0.76% (rev) / 1.10% (visits)	0.76% (rev) / 1.10% (visits)

St. Mary's County – Payer Mix

Payer	2026	2027	2028
Medicare	78.48% (rev) / 74.30% (visits)	75.53% (rev) / 71.30% (visits)	72.56% (rev) / 68.30% (visits)
MA	8.70% (rev) / 8.90% (visits)	10.68% (rev) / 10.90% (visits)	12.68% (rev) / 12.90% (visits)
Medicaid	1.44% (rev) / 4.20% (visits)	1.45% (rev) / 4.20% (visits)	1.45% (rev) / 4.20% (visits)
Commercial	10.63% (rev) / 11.50% (visits)	11.59% (rev) / 12.50% (visits)	12.55% (rev) / 13.50% (visits)
Other	0.76% (rev) / 1.10% (visits)	0.76% (rev) / 1.10% (visits)	0.76% (rev) / 1.10% (visits)

TABLE 5. STAFFING INFORMATION

(Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties (the “Six-County Service Area”))

Note: Current No. of FTEs = 0 for all positions (new applicant). FTEs calculated as 2,080 paid hours/year.

TABLE 5 — PROJECTED YEAR 2026

Position Title	Current No. of FTEs Agency Staff	Current No. of FTEs Contract Staff	Change in FTEs (+/-) Agency Staff	Change in FTEs (+/-) Contract Staff	Average Salary Agency Staff	Average Salary Contract Staff	TOTAL SALARY EXPENSE Agency Staff	TOTAL SALARY EXPENSE Contract Staff
Administrative Personnel	0.00	0.00	1.00	0.00	\$90,626	-	\$90,626	-
Registered Nurse	0.00	0.00	1.50	0.00	\$95,534	-	\$143,302	-
Licensed Practical Nurse	0.00	0.00	0.50	0.00	\$65,603	-	\$32,802	-
Physical Therapist	0.00	0.00	0.00	0.30	-	\$96,782	-	\$29,035
Occupational Therapist	0.00	0.00	0.00	0.20	-	\$96,595	-	\$19,319
Speech Therapist	0.00	0.00	0.00	0.10	-	\$98,114	-	\$9,811
Home Health Aide	0.00	0.00	1.00	0.00	\$41,912	-	\$41,912	-
Medical Social Worker	0.00	0.00	0.20	0.00	\$76,211	-	\$15,242	-
Other (Please specify.) — (e.g., QA/Compliance Support)	0.00	0.00	0.00	0.00	-	-	-	-
Benefits							\$71,254	-
TOTAL							\$395,137	\$58,165

* Benefits calculated as 22% of Agency Staff salaries (wages + payroll taxes + fringe benefits).

TABLE 5 — PROJECTED YEAR 2027

Position Title	Current No. of FTEs Agency Staff	Current No. of FTEs Contract Staff	Change in FTEs (+/-) Agency Staff	Change in FTEs (+/-) Contract Staff	Average Salary Agency Staff	Average Salary Contract Staff	TOTAL SALARY EXPENSE Agency Staff	TOTAL SALARY EXPENSE Contract Staff
Administrative Personnel	0.00	0.00	1.50	0.00	\$90,626	-	\$135,938	-
Registered Nurse	0.00	0.00	3.00	0.00	\$95,534	-	\$286,603	-
Licensed Practical Nurse	0.00	0.00	1.00	0.00	\$65,603	-	\$65,603	-
Physical Therapist	0.00	0.00	0.00	0.60	-	\$96,782	-	\$58,069
Occupational Therapist	0.00	0.00	0.00	0.40	-	\$96,595	-	\$38,638
Speech Therapist	0.00	0.00	0.00	0.20	-	\$98,114	-	\$19,623
Home Health Aide	0.00	0.00	2.50	0.00	\$41,912	-	\$104,780	-
Medical Social Worker	0.00	0.00	0.50	0.00	\$76,211	-	\$38,106	-
Other (Please specify.) — (e.g., QA/Compliance Support)	0.00	0.00	0.00	0.00	-	-	-	-
Benefits							\$138,827	-
TOTAL							\$769,857	\$116,330

* Benefits calculated as 22% of Agency Staff salaries (wages + payroll taxes + fringe benefits).

TABLE 5 — PROJECTED YEAR 2028

Position Title	Current No. of FTEs Agency Staff	Current No. of FTEs Contract Staff	Change in FTEs (+/-) Agency Staff	Change in FTEs (+/-) Contract Staff	Average Salary Agency Staff	Average Salary Contract Staff	TOTAL SALARY EXPENSE Agency Staff	TOTAL SALARY EXPENSE Contract Staff
Administrative Personnel	0.00	0.00	2.00	0.00	\$90,626	-	\$181,251	-
Registered Nurse	0.00	0.00	4.50	0.00	\$95,534	-	\$429,905	-
Licensed Practical Nurse	0.00	0.00	1.50	0.00	\$65,603	-	\$98,405	-
Physical Therapist	0.00	0.00	0.00	1.00	-	\$96,782	-	\$96,782
Occupational Therapist	0.00	0.00	0.00	0.70	-	\$96,595	-	\$67,617
Speech Therapist	0.00	0.00	0.00	0.30	-	\$98,114	-	\$29,434
Home Health Aide	0.00	0.00	4.00	0.00	\$41,912	-	\$167,648	-
Medical Social Worker	0.00	0.00	0.80	0.00	\$76,211	-	\$60,969	-
Other (Please specify.) — (e.g., QA/Compliance Support)	0.00	0.00	0.00	0.00	-	-	-	-
Benefits							\$206,399	-
TOTAL							\$1,144,577	\$193,833

* Benefits calculated as 22% of Agency Staff salaries (wages + payroll taxes + fringe benefits).

EXHIBITS

EXHIBIT 1

Organizational Structure

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS

Articles of Incorporation & SDAT printout

Proposed HHA Organizational Chart

RSA vs Proposed HHA Operational Separation Matrix

STATE OF MARYLAND
Department of Assessments and Taxation

I, BOB YEAGER OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF THE STATE OF MARYLAND, DO HEREBY CERTIFY THAT THE DEPARTMENT, BY LAWS OF THE STATE, IS THE CUSTODIAN OF THE RECORDS OF THIS STATE RELATING TO THE FORFEITURE OR SUSPENSION OF CORPORATIONS, OR THE RIGHTS OF CORPORATIONS TO TRANSACT BUSINESS IN THIS STATE, AND THAT I AM THE PROPER OFFICER TO EXECUTE THIS CERTIFICATE.

I FURTHER CERTIFY THAT QUALITY ONE CARE HOME HEALTH, INC. (D14077978), INCORPORATED APRIL 21, 2011, IS A CORPORATION DULY INCORPORATED AND EXISTING UNDER AND BY VIRTUE OF THE LAWS OF MARYLAND AND THE CORPORATION HAS FILED ALL ANNUAL REPORTS REQUIRED, HAS NO OUTSTANDING LATE FILING PENALTIES ON THOSE REPORTS, AND HAS A RESIDENT AGENT. THEREFORE, THE CORPORATION IS AT THE TIME OF THIS CERTIFICATE IN GOOD STANDING WITH THIS DEPARTMENT AND DULY AUTHORIZED TO EXERCISE ALL THE POWERS RECITED IN ITS CHARTER OR CERTIFICATE OF INCORPORATION, AND TO TRANSACT BUSINESS IN MARYLAND.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY SIGNATURE AND AFFIXED THE SEAL OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF MARYLAND AT BALTIMORE ON THIS JANUARY 09, 2026.



Bob Yeager
Director



700 East Pratt Street, 2nd Flr, Ste 2700, Baltimore, Maryland 21202
Telephone Baltimore Metro (410) 767-1344 / Outside Baltimore Metro (888) 246-5941
MRS (Maryland Relay Service) (800) 735-2258 TT/Voice

Online Certificate Authentication Code: RL00s2p8FUSQqrAKAPq6_Q
To verify the Authentication Code, visit <http://dat.maryland.gov/verify>

CORPORATE CHARTER APPROVAL SHEET

**** EXPEDITED SERVICE ****

**** KEEP WITH DOCUMENT ****

DOCUMENT CODE 80 BUSINESS CODE 03

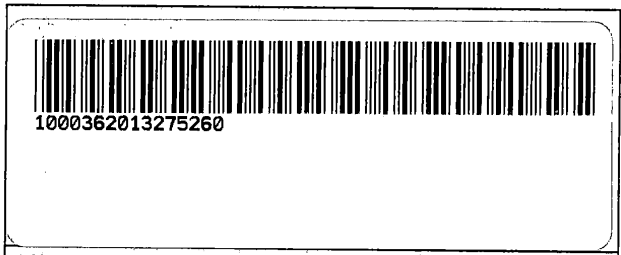
D14077978

Close _____ Stock Nonstock _____

P.A. _____ Religious _____

Merging /Converting _____

Surviving/Resulting _____



ID # D14077978 ACK # 1000362013275260
PAGES: 0002
QUALITY ONE CARE HOME HEALTH, INC.

07/20/2021 AT 01:33 P WO # 0005081052

New Name _____

**CERTIFIED
COPY MADE**

FEES REMITTED

Base Fee:	<u>25</u>
Org. & Cap. Fee:	_____
Expedite Fee:	<u>50</u>
Penalty:	_____
State Recordation Tax:	_____
State Transfer Tax:	_____
Certified Copies:	_____
Copy Fee:	<u>21</u>
Certificates:	_____
Certificate of Status Fee:	_____
Personal Property Filings:	_____
NP Fund:	_____
Other:	<u>84 extra</u>
TOTAL FEES:	<u>100</u>

- Change of Name
- Change of Principal Office
- Change of Resident Agent
- Change of Resident Agent Address
- Resignation of Resident Agent
- Designation of Resident Agent and Resident Agent's Address
- Change of Business Code
- Adoption of Assumed Name
- Other Change(s)

Credit Card _____ Check _____ Cash _____

_____ Documents on _____ Checks

Approved By: ly

Keyed By: _____

COMMENT(S):

Code _____

Attention: _____

QUALITY ONE CARE HOME HEALTH, INC.
12510 PROSPERITY DR.
SUITE 320
SILVER SPRING MD 20902

Stamp Work Order and Customer Number HERE

CUST ID: 0003864476
 WORK ORDER: 0005081052
 DATE: 07-27-2021 01:21 PM
 AMT. PAID: \$100.00

RESOLUTION TO CHANGE PRINCIPAL OFFICE OR RESIDENT AGENT

The directors/stockholders/general partner/authorized person of

QUALITY ONE CARE HOME HEALTH, INC.

(Name of Entity)

organized under the laws of MARYLAND passed the following resolution:
(State)

(Check applicable boxes)

The principal office is changed from: (old address)

12510 PROSPERITY DR, SUITE # 32, SILVER SPRING MD 20904

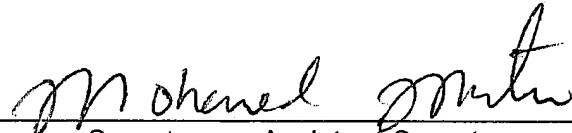
to: (new address)

9221 COLESVILLE R,D SILVER SPRING, MD 20910

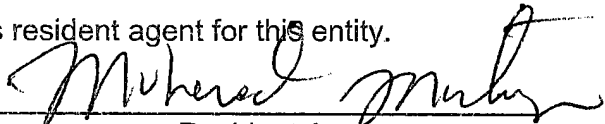
The name and address of the resident agent is changed from:

to:

I certify under penalties of perjury the foregoing is true.

Signed 
Secretary or Assistant Secretary
General Partner
Authorized Person

I hereby consent to my designation in this document as resident agent for this entity.

Signed 
Resident Agent

2021 JUL 20 1:33 PM

CUST ID:0003864476
WORK ORDER:0005081052
DATE:07-27-2021 01:21 PM
AMT. PAID:\$100.00

CORPORATE CHARTER APPROVAL SHEET

**** EXPEDITED SERVICE ****

**** KEEP WITH DOCUMENT ****

DOCUMENT CODE 18A BUSINESS CODE _____

D14077978

Close _____ Stock _____ Nonstock

P.A. _____ Religious _____

Merging (Transferor) _____

Surviving (Transferee) _____



Affix Barcode Label Here
ID # D14077978 ACK # 1000362006751038
PAGES: 0003
QUALITY ONE CARE HOME HEALTH INC.
07/23/2014 AT 11:37 A WO # 0004335317

New Name Quality One Care Home Health Inc.

FEES REMITTED

Base Fee:	<u>100</u>
Org. & Cap. Fee:	_____
Expedite Fee:	<u>70</u>
Penalty:	_____
State Recordation Tax:	_____
State Transfer Tax:	_____
Certified Copies	_____
Copy Fee:	_____
Certificates	_____
Certificate of Status Fee:	<u>20</u>
Personal Property Filings:	<u>900</u>
Mail Processing Fee:	_____
Other:	_____
TOTAL FEES:	<u>1090</u>

<input checked="" type="checkbox"/>	Change of Name
<input checked="" type="checkbox"/>	Change of Principal Office
<input checked="" type="checkbox"/>	Change of Resident Agent
_____	Change of Resident Agent Address
_____	Resignation of Resident Agent
_____	Designation of Resident Agent and Resident Agent's Address
_____	Change of Business Code
_____	Adoption of Assumed Name
_____	Other Change(s)

Credit Card _____ Check Cash _____

_____ Documents on _____ Checks

Approved By: [Signature]

Keyed By: _____

COMMENT(S):

recd 07/23-2014

Code _____

Attention: _____

Mail: Names and Address _____

**MOHAMED MATOPE
10318 CASTLEHEDGE TER
SILVER SPRING MD 20902-5807**

Stamp Work Order and Customer Number HERE

CUST ID: 0003118737
WORK ORDER: 0004335317
DATE: 07-23-2014 11:37 AM
AMT. PAID: \$1,090.00

State of Maryland
Department of Assessments and Taxation
Charter Division

ARTICLES OF REVIVAL
FOR

Quality one Care inc.

(Insert exact name of corporation as it appears on records of the State Department of Assessments and Taxation)

FIRST: The name of the corporation at the time the charter was forfeited was

QUALITY ONE CARE, INC.

SECOND: The name which the corporation will use after revival is

QUALITY ONE CARE HOME HEALTH INC.

THIRD: The address of the principal office in this state is

8209 Fenton Street, Suite # 9, Silver Spring MD 20910

FOURTH: The name and address of the resident agent is

~~Mohamed Matoppe / ELIZABETH LUANDA MOHAMED MATOPPE~~
10318 Castle Hedge Terrace, Silver Spring, MD 20902.

FIFTH: These Articles of Revival are for the purpose of reviving the charter of the corporation.

SIXTH: At or prior to the filing of these Articles of Revival, the corporation has (a) Paid all fees required by law; (b) Filed all annual reports which should have been filed by the corporation if its charter had not been forfeited; (c) Paid all state and local taxes, except taxes on real estate, and all interest and penalties due by the corporation or which would have become due if the charter had not been forfeited whether or not barred by limitations.

Revised 05/02

I hereby consent to my designation in this document as resident agent for this corporation.

M. Mohamed Matoppe

SIGNED: Resident Agent

CUST ID: 0003118737
WORK ORDER: 0004335317
DATE: 07-23-2014 11:37 AM
AMT. PAID: \$1,090.00

06/03

om 801 - Baltimore, Maryland 21201
97 - TTY Users call Maryland Relay 1-800-735-2258
1 - website: <http://www.dat.state.md.us>

CORPORATE CHARTER APPROVAL SHEET

****EXPEDITED SERVICE****

**** KEEP WITH DOCUMENT ****

DOCUMENT CODE 02 BUSINESS CODE 03

Close _____ Stock Nonstock _____

P.A. _____ Religious _____

Merging (Transferor) _____

Surviving (Transferee) _____



ID # D14077978 ACK # 1000362001593401
PAGES: 0004
QUALITY ONE CARE INC.

04/21/2011 AT 01:27 P WO # 0003795410

New Name _____

FEES REMITTED

Base Fee:	<u>100</u>
Org. & Cap. Fee:	<u>20</u>
Expedite Fee:	<u>70</u>
Penalty:	_____
State Recordation Tax:	_____
State Transfer Tax:	_____
<u>1</u> Certified Copies	_____
Copy Fee:	<u>23</u>
Certificates	_____
Certificate of Status Fee:	_____
Personal Property Filings:	_____
Mail Processing Fee:	_____
Other:	_____
TOTAL FEES:	<u>213</u>

Credit Card _____ Check Cash _____

_____ Documents on _____ Checks

Approved By: 15

Keyed By: _____

COMMENT(S):

- _____ Change of Name
- _____ Change of Principal Office
- _____ Change of Resident Agent
- _____ Change of Resident Agent Address
- _____ Resignation of Resident Agent
- _____ Designation of Resident Agent and Resident Agent's Address
- _____ Change of Business Code
- _____ Adoption of Assumed Name
- _____ Other Change(s)

Code _____

Attention: _____

Mail: Name and Address

12318 CASTLE HEDGE TERRACE
SILVER SPRING MD 20902

VERIFIED
COPY MADE

Stamp Work Order and Customer Number HERE

CUST ID: 0002578830
WORK ORDER: 0003795410
DATE: 04-21-2011 01:27 PM
AMT. PAID: \$213.00

ARTICLE OF INCORPORATION
OF
QUALITY ONE CARE INC.

FIRST:

I, Elizabeth Luanda. Whose address is 10318 Castle Hedge Terrace, Silver Spring MD, 20902 being at least eighteen (18) years of age, hereby form a corporation under and by virtue of the General Laws of the State of Maryland, specifically Titles 1-5 of Corporations and Associations Article of the Maryland Annotated Code.

SECOND:

The name of the corporation shall be Quality One Care. INC

THIRD:

The purpose for which the corporation is formed is to engage in general professional home healthcare services and Nursing staffing agency.

To accomplish the foregoing purpose, the corporation shall carry out the following activities;

1. Provide skilled healthcare services to patients of all ages in their homes, healthcare facilities or chosen place of residence.
2. Refer health care professionals to render temporary nursing and other health care services in the homes and in the health care facilities such as hospitals, nursing homes, group homes and assisted living homes.
3. To provide professional medical transportation (Ambulance) to the patients.
4. To provide medical equipments to the patients.
5. To provide pharmaceutical services to the patients.

FORTH:

The post office address of the principal office of the Corporation in Maryland is 10318 Castle Hedge Terrace, Silver Spring, Montgomery County, MD, 20902.

FIRTH:

The name of the resident agent of the corporation in Maryland is Elizabeth Luanda. Whose address is; 10318 Castle Hedge Terrace, SilverSpring, MD, 20902.

SIXTH

The maximum number of shares this Corporation is authorized to issue is 100,000 par value \$0.01 per share, all of which shall be Common Shares. All Common Shares shall be identical with each other in every respect and the holders of Common Shares shall be entitled to one vote for each share on all matters on which shareholders have the right to vote. The corporation will not commence business until at least one thousand dollars (\$1,000) has been received as initial capitalization.

SEVENTH

The number of directors constituting the initial board of directors shall be four, which number may be increased or decreased pursuant to the by-laws of the Corporation, provided that the number of directors shall never be less than the minimum number permitted by Section 2-402 of the Corporations and Associations Article of the Annotated Code of Maryland, as amended. The names of the directors who shall act until the first annual meeting and until their successors are duly chosen and qualified are:

1. Mohsin Jabir
Kinondoni, Mikocheni, 1914, Dar-es -salaam, Tanzania.
2. Said Salum
Tabata ,Segerea,14210 Dar-es -salaam,Tanzania
3. Mansor Mohsin
Sinza, Mabatini,1094 ,Dar-es-salaam,Tanzania.
4. Johnson Abe Fapohunda
409 Quackensbos Street, NE Washington DC 20011.

EIGHTH: LIMITATION OF LIABILITY

The following provisions are hereby adopted for the purposes of defining, limiting and regulating the powers of the Corporation and of the directors and stockholders;

The private property of the members, directors and staffs of the Corporation shall not be liable for its corporate debts. Directors, stockholders and staffs of Corporation shall not be liable to the Corporation for money damages. The purpose of this limitation of liability is to limit liability to the maximum extent that the liability of directors staffs, and stockholders of Maryland corporations is permitted to be limited by Maryland law, as amended. This limitation on liability shall apply to events occurring at the time a person serves as a director or staffs of the Corporation whether or not such person serves as a director or staff at the time of any proceeding in which liability is asserted.

To the maximum extent permitted by Maryland law, the Corporation shall indemnify its currently acting and its former directors and officers against any and all liabilities and expenses incurred in connection with their services in such capacities, and shall indemnify its currently acting and its former officers to the full extent that indemnification shall be provided to directors, and shall indemnify, to the same extent, persons who serve and have served, at its request as a director, officer, partner, trustee, employee or agent of another corporation, partnership, joint venture or other enterprise. The Corporation shall advance expenses to its directors and officers and the other persons referred to above to the extent permitted by Maryland law. This indemnification of directors and officers shall also apply to directors and officers who are also employees, in their capacity as employees. The Board of Directors may by Bylaw, resolution or agreement make further provision for indemnification of employees and agents to the extent permitted by Maryland law.

References to Maryland law shall include the Maryland General Corporation Law as from time to time amended. Neither the repeal or amendment of this Article Eleven, nor any other amendment to these Articles of Incorporation, shall eliminate or reduce the protection afforded to any person by the foregoing provisions of this Article Eighth with

respect to any act or omission which shall have occurred prior to such repeal or amendment.

NINETH;

The duration of the Corporation shall be perpetual until such time as the Corporation is dissolved according to the laws of the State of Maryland and of the bylaws of this Corporation.

TENTH: SELF DEALING

No contract or other transaction between the corporation and other corporations, in the absence of fraud, shall be affected or invalidated by the fact that any one or more of the directors of the corporation is or are interested in a contract or transaction, or are directors or officers of any other corporation, and any director or directors, individually or jointly, may be a party or parties to, or may be interested in such contract, act or transaction, or in any way connected with such person or person's firm or corporation, and each and every person who may become a director of the corporation is hereby relieved from any liability that might otherwise exist from this contracting with the corporation for the benefit of himself or any firm, association or corporation in which he may be in any way interested. Any director of the corporation may vote upon any transaction with the corporation without regard to the fact that he is also a director of such subsidiary or corporation.

IN WITNESS WHEREOF, I have signed these Articles of Incorporation on March 23, 2011, and severally acknowledge the same to be my act.

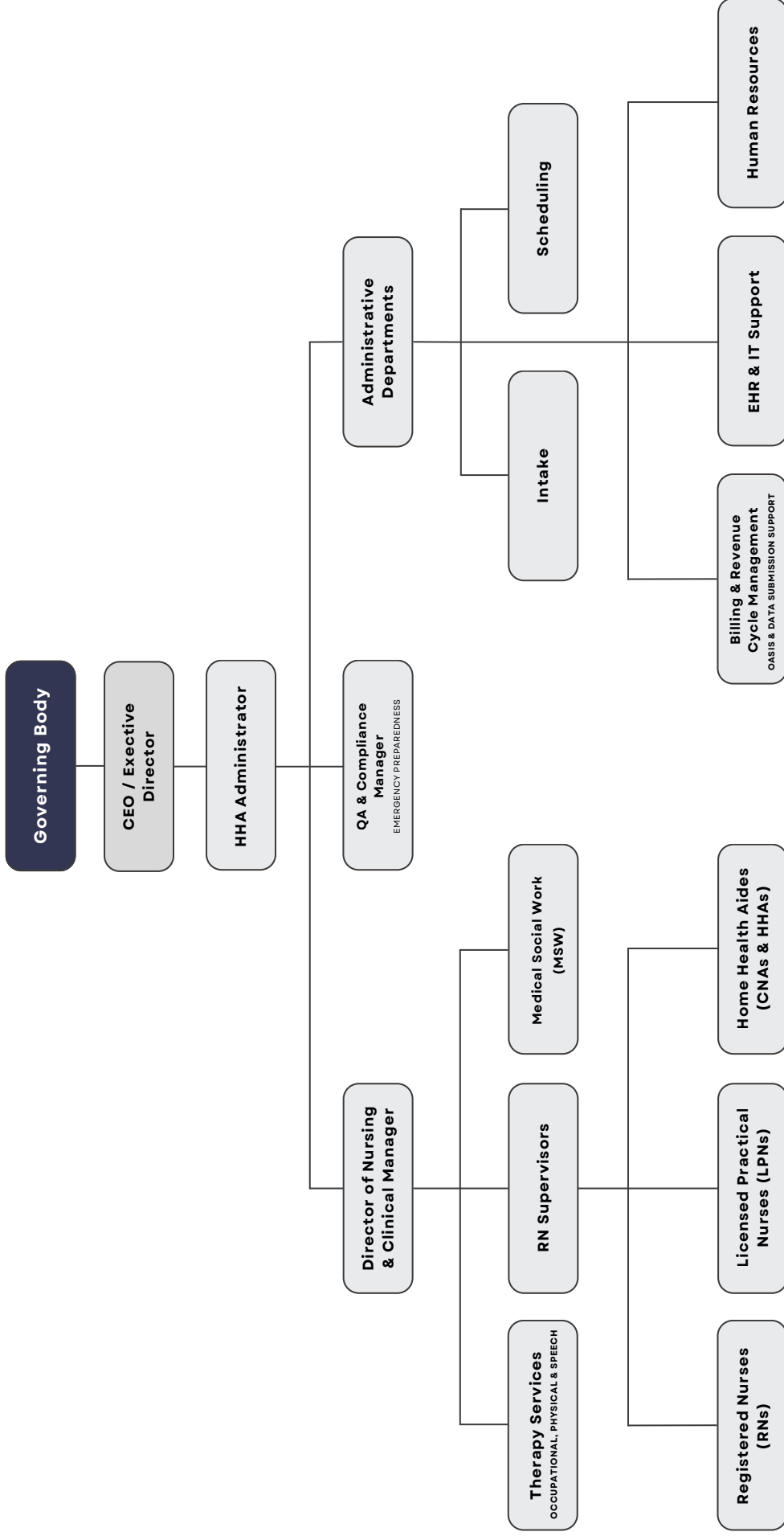
NAME: ELIZABETH LUANDA

SIGNATURE *EL*

DATE 07/20/2011

CUST ID:0002578830
WORK ORDER:0003795410
DATE:04-21-2011 01:27 PM
AMT. PAID:\$213.00

PROPOSED HHA ORGANIZATIONAL CHART



QUALITY ONE CARE HOME HEALTH, INC

Home Health Agency Organizational Chart

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

Organizational Structure: RSA vs HHA Separation Matrix

Operational Area	Existing RSA Operations	Proposed HHA Operations	Separation Mechanism / Controls
Licensure / Regulatory Status	Licensed as Residential Service Agency (RSA) under Maryland regulations	Will be licensed and operated as a Maryland Home Health Agency and pursue Medicare certification	Separate licensure line; HHA policies and survey readiness maintained separately
Governing Body Oversight	Governing body oversight for RSA scope	Governing body oversight for HHA scope (separate agenda items and compliance reporting)	Separate oversight reporting tracks and compliance documentation by program
Administrator Responsibility	RSA operations overseen by RSA management	HHA Administrator has direct responsibility for HHA operations and compliance	Administrator role specifically assigned to HHA and accountable for HHA requirements
Clinical Leadership	RSA care coordination and nursing services as applicable under RSA scope	Director of Nursing / Clinical Manager , RN Supervisors, and clinical discipline leaders oversee HHA clinical care	Clinical leadership structure dedicated to HHA; HHA CoPs drive clinical governance
Scope of Services	RSA services per RSA licensure	Skilled nursing, home health aide services, PT/OT/SLP, MSW as required under HHA standards	Separate service protocols and eligibility criteria by program
Patient Admission & Eligibility	RSA admission criteria and service agreements	HHA admissions based on medical necessity, physician orders, payer requirements, and plan of care	Distinct admissions policies and documentation requirements
Patient Rights / Notices	RSA patient rights materials	HHA patient rights materials consistent with HHA CoPs and payer requirements	Separate patient rights policies and notices tailored to HHA
Clinical Documentation / Medical Record	RSA client documentation systems	HHA clinical documentation system with HHA-specific assessments (including OASIS where applicable)	Separate medical record protocols; no commingling of patient records
Billing & Revenue Cycle	RSA billing processes and payer enrollment	HHA billing, coding, claims submission, and OASIS/data submission support aligned to HHA requirements	Separate payer enrollments and claims workflows; dedicated cost center and audit controls
Staffing Assignments	RSA staff roles and job descriptions	HHA staff roles and job descriptions (RN/LPN/HHA, therapy, MSW, intake, scheduling)	HHA staff assigned under HHA org chart and HHA policies; training aligned to HHA standards
Quality Assurance - QAPI	RSA quality processes under RSA scope	HHA QAPI Program with required performance improvement, patient satisfaction measures, and compliance monitoring	Separate QAPI plan and metrics; dedicated QA & Compliance Manager role shown on org chart
Emergency Preparedness	RSA EP and infection control policies	HHA EP and infection prevention program maintained under compliance function	Separate EP plan elements and documentation; tracked under HHA compliance

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

Contracts / Referral Linkages	RSA referral relationships	HHA referral relationships with hospitals, physicians, and community partners	Referral and linkage documentation maintained for HHA operations separately
Financial Accounting / Cost Tracking	RSA financial tracking	HHA financial tracking	Separate cost center and accounting records; shared expenses allocated using documented methodology
Shared Corporate Support (if applicable)	Corporate-level services may support RSA (HR/IT, etc.)	Corporate-level services may support HHA (HR/IT, etc.)	Any shared support is provided under documented administrative services arrangement; HHA retains operational authority

EXHIBIT 2

Financial Solvency Documentation

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS

CPA Letter / Financial Assurance Letter

Audited Financials & Financial
Statements

Financial Tables & Assumptions



SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA
MONIKA BENKOVIC, CPA
RADKA WINDT, BUSINESS SERVICES
MANAGER

Date: December 22, 2025

Maryland Health Care Commission
ATTN: Certificate of Need Review

RE: Financial Solvency / Financial Assurance Letter

Applicant: Quality One Care Home Health, Inc. ("Applicant")

Project: Certificate of Need – Proposed Home Health Agency

Service Area: Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties, Maryland

To Whom It May Concern:

I am writing on behalf of Mr. Mohamed Matope, the 100% sole legal and beneficial owner of Quality One Care Home Health, Inc., located at 9221 Colesville Rd, Silver Spring, MD 20910. As Quality One Care's accountant and financial advisor, I am providing this letter in support of the Applicant's Certificate of Need ("CON") application for a proposed Home Health Agency serving the six-county region identified above.

Based on my review of the Applicant's financial records and supporting documentation, including financial statements as of October 31, 2025, it is my professional opinion that the Applicant has sufficient financial resources and access to capital to fund the start-up and initial operating costs of the proposed Home Health Agency and to sustain operations during the start-up period as patient volume develops.

As of October 31, 2025, the Applicant reported approximately \$630,851 in cash and cash equivalents, total assets of approximately \$994,185, and generated \$17,460,992 in service revenues for the period ended October 31, 2025, with net income of \$89,344.

This letter is provided solely for the purpose of supporting the Applicant's CON application and does not constitute an audit opinion. My review was based on information provided by management and was limited to procedures customary for this type of financial assurance letter.

Should you require further verification or additional documentation concerning Mr. Matope's ownership or financial capacity, please feel free to contact me directly. I trust this certification will assist in your review.

Sincerely,

A handwritten signature in cursive script that reads "Paul Sullivan".

Paul Sullivan
Certified Public Accountant
Sullivan & Company, LLC
psullivan@esullivan.net
(301) 657-8080



SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA
MONIKA BENKOVIC, CPA
RADKA WINDT, BUSINESS SERVICES
MANAGER

TO: Mohamed Matope
Quality One Care Home Health, Inc.

Date: January 8, 2026

The following items are enclosed:

- E-file authorization forms for signature and tax returns for review**
E-file authorization form(s) and tax returns are in your portal. You should review the tax returns before returning the signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:
 - a. Return via DocuSign
 - b. Mail to our office via First Class Mail
 - c. Upload signed E-file forms in your portal

- Tax Reports that cannot be filed electronically/must be filed on paper with instructions for filing**
Follow the enclosed instructions. Copies of your tax report(s) are in your portal.

- Client Agreement and/or Engagement Letter**
Electronically sign via DocuSign by clicking each tag and following the instructions to add your electronic signature or initials where required. Confirm your signature by clicking "FINISH". Alternatively, mail, fax, or upload to your portal. Follow any terms listed at the asterisk (*) on the Client Agreement.

- Original documents and/or paper copies of tax returns**

- 10/31/2025 Financial Statements**

- If you have questions, call Paul at (301) 657- 8080 extension 102.**

Remarks:

As a client of Sullivan & Company, CPAs, you receive a secure client portal. The portal is the best way to send documents to us and receive them. To access the portal, go to esullivan.net, client portal, and enter your username and password to log in and access the applicable folder. If you need assistance navigating the portal, call our office, and one of our administrative team members can assist you.

Signed: *Paul Sullivan*
Jane Huserova

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis

As of October 31, 2025

	Oct 31, 25
ASSETS	
Current Assets	
Checking/Savings	
First Citizens Bank 2213	595,646
Truist 5249	30,064
Truist 5257	500
Truist 5265	3,275
Truist 5273	1,366
	630,851
Total Checking/Savings	630,851
Accounts Receivable	
Accounts Receivable (A/R)	(1,000,000)
	(1,000,000)
Total Accounts Receivable	(1,000,000)
Other Current Assets	
Undeposited Funds	1,000,000
	1,000,000
Total Other Current Assets	1,000,000
	630,851
Total Current Assets	630,851
Fixed Assets	
Accum. Depreciation	(179,475)
Computers	34,279
Furnitures and Equipment	47,303
Leasehold Improvements	8,719
Leasehold Improvements E&M Inve	445,123
Printers	7,386
	363,334
Total Fixed Assets	363,334
	994,185
TOTAL ASSETS	994,185
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Child Support Payable	96
	96
Total Other Current Liabilities	96
	96
Total Current Liabilities	96
Long Term Liabilities	
EIDL SBAD TREAS	119,854
	119,854
Total Long Term Liabilities	119,854
	119,950
Total Liabilities	119,950

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis
As of October 31, 2025

	<u>Oct 31, 25</u>
Equity	
Capital	20,000
Distributions Mohamed	(341,742)
Retained Earnings	1,106,633
Net Income	<u>89,344</u>
Total Equity	<u>874,235</u>
TOTAL LIABILITIES & EQUITY	<u><u>994,185</u></u>

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statements of Revenues and Expenses - Tax Basis

For the Periods Ended October 31, 2025 and 2024

	Jan - Oct 25	Jan - Oct 24	% of Income
Ordinary Income/Expense			
Income			
Service Revenues	17,460,992	14,049,549	100%
Total Income	17,460,992	14,049,549	100%
Cost of Goods Sold			
Business Telehealth	0	250,000	0%
Direct Wages	3,878,999	2,181,160	22%
Subcontractors - COS	12,528,603	11,077,903	72%
Total COGS	16,407,602	13,509,063	94%
Gross Profit	1,053,390	540,486	6%
Expense			
Accounting	20,590	18,890	0%
Advertising	0	9,000	0%
Auto Expenses	1,313	730	0%
Bank & Merchant Fees	1,637	1,082	0%
CHARITY	5,297	0	0%
Depreciation Expense	25,485	19,025	0%
Dues & Subscriptions	8,854	7,410	0%
Health Insurance	1,942	0	0%
Insurance	16,343	49,653	0%
Legal & Professional Fees	1,000	92,800	0%
Meals Business	1,410	0	0%
Office Expenses	79,522	28,439	0%
Payroll Service Fees	30,729	7,328	0%
Pension Expense	34,566	40,219	0%
Rent or Lease	15,000	218,115	0%
Repair & Maintenance	166,725	89,520	1%
Salaries and Wages, Other	0	270,753	0%
Salary, Officer	130,560	157,000	1%
Software	59,338	17,399	0%
Taxes & Licenses	314,804	215,991	2%
Telephone Expenses	12,244	14,218	0%
Travel	3,590	0	0%
Utilities	8,153	13,481	0%
Total Expense	939,100	1,271,054	5%
Net Ordinary Income	114,289	(730,568)	1%
Other Income/Expense			
Other Income			
Interest Earned	54	12	0%
Total Other Income	54	12	0%

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statements of Revenues and Expenses - Tax Basis

For the Periods Ended October 31, 2025 and 2024

	<u>Jan - Oct 25</u>	<u>Jan - Oct 24</u>	<u>% of Income</u>
Other Expense			
Maryland Income Taxes	25,000	0	0%
Total Other Expense	25,000	0	0%
Net Other Income	(24,946)	12	(0)%
Net Income	<u>89,344</u>	<u>(730,556)</u>	<u>1%</u>

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.



SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA
MONIKA BENKOVIC, CPA
RADKA WINDT, BUSINESS SERVICES
MANAGER

TO: Mohamed Matope
Quality One Care Home Health, Inc.

Date: March 25, 2025

The following items are enclosed:

- E-file authorization forms for signature and tax returns for review**
E-file authorization form(s) and tax returns are in your portal. You should review the tax returns before returning the signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:
 - a. Return via DocuSign
 - b. Mail to our office via First Class Mail
 - c. Upload signed E-file forms in your portal
- Tax Reports that cannot be filed electronically/must be filed on paper with instructions for filing**
Follow the enclosed instructions. Copies of your tax report(s) are in your portal.
- Client Agreement and/or Engagement Letter**
Electronically sign via DocuSign by clicking each tag and following the instructions to add your electronic signature or initials where required. Confirm your signature by clicking "FINISH". Alternatively, mail, fax, or upload to your portal. Follow any terms listed at the asterisk (*) on the Client Agreement.
- Original documents and/or paper copies of tax returns**
- 12/31/24 Financial Statements
- If you have questions, call Paul at (301) 657- 8080 extension 102.**

Remarks:

As a client of Sullivan & Company, CPAs, you receive a secure client portal. The portal is the best way to send documents to us and receive them. To access the portal, go to esullivan.net, client portal, and enter your username and password to log in and access the applicable folder. If you need assistance navigating the portal, call our office, and one of our administrative team members can assist you.

Signed: *Paul Sullivan*
Karla Romero

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis

December 31, 2024

	Dec 31, 24
ASSETS	
Current Assets	
Checking/Savings	
First Citizens Bank 2213	779,563
Truist 5249	319,554
Truist 5257	500
Truist 5265	30,357
Truist 5273	1,912
Total Checking/Savings	1,131,887
Accounts Receivable	
Accounts Receivable (A/R)	(1,000,000)
Total Accounts Receivable	(1,000,000)
Other Current Assets	
Payroll Tax Receivable	71,286
Undeposited Funds	1,000,000
Total Other Current Assets	1,071,286
Total Current Assets	1,203,172
Fixed Assets	
Accum. Depreciation	(153,990)
Computers	34,279
Furnitures and Equipment	47,303
Leasehold Improvements E&M Inve	406,777
Printers	7,386
Total Fixed Assets	341,755
TOTAL ASSETS	1,544,927

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis
December 31, 2024

	<u>Dec 31, 24</u>
LIABILITIES & EQUITY	
Liabilities	
Long Term Liabilities	
EIDL SBAD TREAS	<u>137,779</u>
Total Long Term Liabilities	<u>137,779</u>
Total Liabilities	137,779
Equity	
Capital	20,000
Contributions Mohamed	291,314
Retained Earnings	1,642,613
Net Loss	<u>(546,779)</u>
Total Equity	<u>1,407,148</u>
TOTAL LIABILITIES & EQUITY	<u><u>1,544,927</u></u>

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statements of Revenues and Expenses - Tax Basis

For the Periods Ended December 31, 2024 and 2023

	Jan - Dec 24	Jan - Dec 23	% of Income
Ordinary Income/Expense			
Income			
Service Revenues	17,235,327	16,482,073	100%
Total Income	17,235,327	16,482,073	100%
Cost of Goods Sold			
Business Telehealth	250,000	0	1%
Direct Wages	2,538,061	2,216,891	15%
Subcontractors - COS	13,379,501	12,437,863	78%
Total COGS	16,167,562	14,654,754	94%
Gross Profit	1,067,764	1,827,319	6%
Expense			
Accounting	27,809	27,379	0%
Advertising	9,000	0	0%
Auto Expenses	8,904	8,222	0%
Bank & Merchant Fees	3,326	626	0%
CHARITY	0	5,000	0%
Depreciation Expense	23,813	21,603	0%
Dues & Subscriptions	37,323	3,280	0%
Education and Training Expen...	0	870	0%
Insurance	56,464	12,665	0%
Interest Expense	0	1,434	0%
Legal & Professional Fees	92,800	94,783	1%
Office Expenses	97,594	64,264	1%
Parking	0	690	0%
Payroll Service Fees	9,282	8,302	0%
Penalties	0	124	0%
Pension Expense	44,225	52,631	0%
Rent or Lease	238,870	258,216	1%
Repair & Maintenance	98,244	68,253	1%
Salaries and Wages, Other	373,344	363,327	2%
Salary, Officer	194,220	226,000	1%
Taxes & Licenses	263,132	227,864	2%
Telephone Expenses	16,675	18,701	0%
Travel	600	5,183	0%
Utilities	13,481	14,905	0%
Total Expense	1,609,106	1,484,322	9%
Net Ordinary Income	(541,342)	342,997	(3)%
Other Income/Expense			
Other Income			
Interest Earned	52	0	0%
Total Other Income	52	0	0%

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statements of Revenues and Expenses - Tax Basis
For the Periods Ended December 31,2024 and 2023

	<u>Jan - Dec 24</u>	<u>Jan - Dec 23</u>	<u>% of Income</u>
Other Expense			
Penalties, Other	5,490	0	0%
Maryland Income Taxes	<u>0</u>	<u>108,413</u>	<u>0%</u>
Total Other Expense	<u>5,490</u>	<u>108,413</u>	<u>0%</u>
Net Other Income	<u>(5,437)</u>	<u>(108,413)</u>	<u>(0)%</u>
Net Income	<u><u>(546,779)</u></u>	<u><u>234,584</u></u>	<u><u>(3)%</u></u>

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: Mohamed Matope

Date: 12/14/24

Quality One Care Home Health, Inc.

The following items are enclosed:

E-file authorization form(s) for signature and tax returns for review. E-file authorization form(s) and tax returns have been placed in your portal. You should review the tax returns before returning signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:

- a. Return through DocuSign c. Upload back into your portal
b. Mail to our office via First Class Mail

Tax report(s) that cannot be filed electronically and must be filed on paper with instructions for filing. Follow the instructions attached. Copy(ies) of your tax report(s) have been placed in your portal.

Client Agreement and/or Engagement Letter. Sign via **DocuSign, mail, fax, or upload to your Portal**. Follow any terms listed at the asterisk (*) on the Client Agreement.

Complete required fields in DocuSign by agreeing to sign electronically. Click each sign tag and follow the instructions to add your electronic signature where required to sign or initial. Confirm your signature by clicking FINISH.

10/31/24 Financial Statements _____

We can review _____ with you. Please call our office to schedule.

As a client of Sullivan & Company, CPAs, you receive a secure client portal. The best way to send documents to us and to receive documents is through this portal. To access the portal: **Go to www.eSullivan.net -> Client Portal. Enter your email address as username, and password. Open the applicable folder once you have logged in.**

Remarks: _____

Call with questions, or if you want our comments. (301) 657-8080

Signed: *Paul Sullivan*
Jane Huserova

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis

As of October 31, 2024

	Oct 31, 24
ASSETS	
Current Assets	
Checking/Savings	
First Citizens Bank 2213	710,513
Truist 5249	99,154
Truist 5257	500
Truist 5265	500
Truist 5273	19,891
	830,559
Accounts Receivable	
Accounts Receivable (A/R)	(1,000,000)
	(1,000,000)
Other Current Assets	
PPP Loan Payments	101,117
Prepaid Payroll Taxes	3,086
Undeposited Funds	1,000,000
	1,104,204
Total Current Assets	934,762
Fixed Assets	
Accum. Depreciation	(149,202)
Computers	34,279
Furnitures and Equipment	34,781
Leasehold Improvements E&M Inve	342,277
Printers	7,386
	269,521
TOTAL ASSETS	1,204,283
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Payroll Liabilities	
401K Payable	2,776
Payroll Liabilities - Other	212
	2,987
Total Payroll Liabilities	2,987
Total Other Current Liabilities	2,987
Total Current Liabilities	2,987
Long Term Liabilities	
EIDL SBAD TREAS	141,364
	141,364
Total Long Term Liabilities	141,364

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis
As of October 31, 2024

	<u>Oct 31, 24</u>
Total Liabilities	144,351
Equity	
Capital	20,000
Distributions Mohamed	214,160
Retained Earnings	1,642,613
Net Income	<u>(816,841)</u>
Total Equity	<u>1,059,932</u>
TOTAL LIABILITIES & EQUITY	<u><u>1,204,283</u></u>

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statements of Revenues and Expenses - Tax Basis

For the Periods Ended October 31, 2024 and 2023

	Jan - Oct 24	Jan - Oct 23	% of Income
Ordinary Income/Expense			
Income			
Service Revenues	14,049,549	13,869,631	100%
Total Income	14,049,549	13,869,631	100%
Cost of Goods Sold			
Business Telehealth	250,000	0	2%
Direct Wages	2,181,160	1,912,651	16%
Subcontractors - COS	11,078,098	10,350,996	79%
Total COGS	13,509,258	12,263,648	96%
Gross Profit	540,292	1,605,983	4%
Expense			
Accounting	20,359	19,427	0%
Advertising	4,000	0	0%
Auto Expenses	10	94	0%
Bank & Merchant Fees	1,082	526	0%
CHARITY	5,000	5,000	0%
Depreciation Expense	19,025	17,858	0%
Dues & Subscriptions	7,410	2,721	0%
Education and Training Expenses	0	870	0%
Insurance	49,653	10,971	0%
Interest Expense	0	1,434	0%
Legal & Professional Fees	92,800	74,938	1%
Office Expenses	28,439	33,151	0%
Parking	720	690	0%
Payroll Service Fees	17,933	6,869	0%
Pension Expense	40,219	45,514	0%
Rent or Lease	218,115	223,680	2%
Repair & Maintenance	154,020	57,153	1%
Salaries and Wages, Other	270,753	319,012	2%
Salary, Officer	166,518	202,000	1%
Software	17,399	41,747	0%
Taxes & Licenses	215,991	201,958	2%
Telephone Expenses	14,218	14,019	0%
Travel	0	2,613	0%
Utilities	13,481	11,732	0%
Total Expense	1,357,145	1,293,974	10%
Net Ordinary Income	(816,853)	312,009	(6)%
Other Income/Expense			
Other Income			
Interest Earned	12	0	0%
Total Other Income	12	0	0%
Other Expense			
Maryland Income Taxes	0	108,413	0%
Total Other Expense	0	108,413	0%

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statements of Revenues and Expenses - Tax Basis
For the Periods Ended October 31, 2024 and 2023

	<u>Jan - Oct 24</u>	<u>Jan - Oct 23</u>	<u>% of Income</u>
Net Other Income	12	(108,413)	0%
Net Income	<u>(816,841)</u>	<u>203,596</u>	<u>(6)%</u>

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
CHRISTOPHER BAILEY, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: _____

Date: _____

The following items are enclosed:

E-file authorization form(s) for signature and tax returns for review. E-file authorization form(s) and tax returns have been placed in your Electronic Mailbox (Sullivan & Company secured portal). You should review the tax returns before returning signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:

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Client Agreement and/or Engagement Letter. Sign and **mail, fax, or upload to your Electronic Mailbox.**

Follow any terms listed at the asterisk (*) on the Client Agreement.

Complete required fields in PandaDoc with signature included and click the Finish button in the top righthand corner to return to our office.

NEW We can review your _____ with you, via a Zoom call if helpful to you.

As a client of Sullivan & Company, CPAs, you receive an Electronic Mailbox. The best way to send documents to us and receive documents is through this Electronic Mailbox. Other than this Electronic Mailbox, First Class Mail is always available.

Remarks: _____

Call with questions, or if you want our comments.

Signed: *Paul Sullivan*
Jane Huserova

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis

As of June 30, 2023

	Jun 30, 23
ASSETS	
Current Assets	
Checking/Savings	
Capital One Checking- NEW--8343	1,580,194
First Citizens Bank 2213	2,292
	1,582,486
Accounts Receivable	
Accounts Receivable (A/R)	(1,300,000)
	(1,300,000)
Other Current Assets	
PPP Loan Payments	101,117
Prepaid 401K Contribution	199
Prepaid Payroll Taxes	3,776
Undeposited Funds	1,300,000
	1,405,092
Total Current Assets	1,687,579
Fixed Assets	
Accum. Depreciation	(119,289)
Computers	34,279
Furnitures and Equipment	34,781
Leasehold Improvements E&M Inve	321,277
Printers	7,386
	278,434
TOTAL ASSETS	1,966,013
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Payroll Liabilities	
Health Insurance	9,376
	9,376
Total Payroll Liabilities	9,376
Total Other Current Liabilities	9,376
Total Current Liabilities	9,376
Long Term Liabilities	
EIDL SBAD TREAS	147,100
	147,100
Total Long Term Liabilities	147,100
Total Liabilities	156,476

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis
As of June 30, 2023

	<u>Jun 30, 23</u>
Equity	
Capital	20,000
Distributions Mohamed	(240,204)
Retained Earnings	1,425,397
Net Income	<u>604,344</u>
Total Equity	<u>1,809,537</u>
TOTAL LIABILITIES & EQUITY	<u><u>1,966,013</u></u>

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statement of Revenues and Expenses - Tax Basis

For the Period Ended June 30, 2023

	Jan - Jun 23	% of Income
Ordinary Income/Expense		
Income		
Service Revenues	8,226,326	100%
Total Income	8,226,326	100%
Cost of Goods Sold		
Direct Wages	1,151,010	14%
Subcontractors - COS	5,772,470	70%
Total COGS	6,923,480	84%
Gross Profit	1,302,846	16%
Expense		
Accounting	14,502	0%
Bank & Merchant Fees	300	0%
CHARITY	3,000	0%
Depreciation Expense	10,715	0%
Dues & Subscriptions	1,610	0%
Education and Training Expenses	600	0%
Insurance	13,083	0%
Interest Expense	1,434	0%
Legal & Professional Fees	11,136	0%
Office Expenses	30,102	0%
Payroll Service Fees	3,903	0%
Pension Expense	27,788	0%
Rent or Lease	49,608	1%
Repair & Maintenance	27,119	0%
Salaries and Wages, Other	193,672	2%
Salary, Officer	122,000	1%
Software	33,525	0%
Taxes & Licenses	117,393	1%
Telephone Expenses	9,622	0%
Travel	792	0%
Utilities	5,367	0%
Total Expense	677,269	8%
Net Ordinary Income	625,577	8%
Other Income/Expense		
Other Expense		
Maryland Income Taxes	21,233	0%
Total Other Expense	21,233	0%
Net Other Income	(21,233)	(0)%
Net Income	604,344	7%

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
CHRISTOPHER BAILEY, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: _____

Date: _____

The following items are enclosed:

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Client Agreement and/or Engagement Letter. Sign and **mail, fax, or upload to your Electronic Mailbox.**

Follow any terms listed at the asterisk (*) on the Client Agreement.

Complete required fields in PandaDoc with signature included and click the Finish button in the top righthand corner to return to our office.

NEW We can review your _____ with you, via a Zoom call if helpful to you.

As a client of Sullivan & Company, CPAs, you receive an Electronic Mailbox. The best way to send documents to us and receive documents is through this Electronic Mailbox. Other than this Electronic Mailbox, First Class Mail is always available.

Remarks: _____

Call with questions, or if you want our comments.

Signed: *Paul Sullivan*
Jane Huserova

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis

As of September 30, 2023

	Sep 30, 23
ASSETS	
Current Assets	
Checking/Savings	
Capital One Checking- NEW--8343	1,277,317
First Citizens Bank 2213	13,648
Total Checking/Savings	1,290,965
Accounts Receivable	
Accounts Receivable (A/R)	(1,300,000)
Total Accounts Receivable	(1,300,000)
Other Current Assets	
PPP Loan Payments	101,117
Prepaid Payroll Taxes	3,776
Undeposited Funds	1,300,000
Total Other Current Assets	1,404,893
Total Current Assets	1,395,858
Fixed Assets	
Accum. Depreciation	(124,646)
Computers	34,279
Furnitures and Equipment	34,781
Leasehold Improvements E&M Inve	321,277
Printers	7,386
Total Fixed Assets	273,077
TOTAL ASSETS	1,668,935
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Payroll Liabilities	
401K Payable	4,139
Health Insurance	9,288
Total Payroll Liabilities	13,427
Total Other Current Liabilities	13,427
Total Current Liabilities	13,427
Long Term Liabilities	
EIDL SBAD TREAS	147,100
Total Long Term Liabilities	147,100
Total Liabilities	160,527

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis
As of September 30, 2023

	<u>Sep 30, 23</u>
Equity	
Capital	20,000
Distributions Mohamed	(226,816)
Retained Earnings	1,425,397
Net Income	<u>289,828</u>
Total Equity	<u>1,508,408</u>
TOTAL LIABILITIES & EQUITY	<u><u>1,668,935</u></u>

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statements of Revenues and Expenses - Tax Basis
For the Periods Ended September 30, 2023 and 2022

	<u>Jan - Sep 23</u>	<u>Jan - Sep 22</u>	<u>% of Income</u>
Ordinary Income/Expense			
Income			
Service Revenues	12,436,521	9,800,800	100%
Total Income	12,436,521	9,800,800	100%
Cost of Goods Sold			
Direct Wages	1,751,047	1,453,783	14%
Subcontractors - COS	9,217,308	6,975,080	74%
Total COGS	10,968,355	8,428,863	88%
Gross Profit	1,468,166	1,371,937	12%
Expense			
Accounting	17,886	10,768	0%
Advertising	0	4,300	0%
Auto Expenses	94	4,688	0%
Bank & Merchant Fees	451	685	0%
CHARITY	5,000	0	0%
Depreciation Expense	16,072	18,542	0%
Dues & Subscriptions	2,441	2,539	0%
Education and Training Expenses	600	0	0%
Insurance	15,624	23,816	0%
Interest Expense	1,434	0	0%
Legal & Professional Fees	23,348	5,987	0%
Meals Business	0	425	0%
Office Expenses	44,710	43,183	0%
Parking	690	1,250	0%
Payroll Service Fees	6,154	5,430	0%
Pension Expense	38,968	3,343	0%
Rent or Lease	134,412	195,295	1%
Repair & Maintenance	50,653	56,077	0%
Salaries and Wages, Other	285,212	75,679	2%
Salary, Officer	178,000	135,600	1%
Software	34,829	0	0%
Taxes & Licenses	187,460	148,519	2%
Telephone Expenses	13,001	10,560	0%
Travel	2,613	852	0%
Utilities	10,274	1,620	0%
Total Expense	1,069,925	749,158	9%
Net Ordinary Income	398,241	622,779	3%
Other Income/Expense			
Other Expense			
Maryland Income Taxes	108,413	71,610	1%
Total Other Expense	108,413	71,610	1%
Net Other Income	(108,413)	(71,610)	(1)%
Net Income	289,828	551,169	2%

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
CHRISTOPHER BAILEY, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: Mohamed Matope

Date: September 30, 2022

Quality One Care Home Health, Inc.

The following items are enclosed:

- E-file authorization form(s) for signature and tax returns for review. E-file authorization form(s) and tax returns have been placed in your Electronic Mailbox (Sullivan & Company secured portal). You should review the tax returns before returning signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:
- a. Upload back into your Electronic Mailbox
 - b. Mail to our office via First Class Mail
- Tax report(s) that cannot be filed electronically and must be filed on paper with instructions for filing. Follow the instructions attached. Copy(ies) of your tax report(s) have been placed in your Electronic Mailbox (Sullivan & Company secured portal).

To access Electronic Mailbox: Go to www.eSullivan.net -> Client Center -> Client Portal. Enter your email address as username, and password. If you can't remember your password, click on **Forgot Password and a new password will be sent to your email to retrieve. Open the applicable folder once you have logged in.**

- Client Agreement and/or Engagement Letter. Sign and **mail, fax, or upload to your Electronic Mailbox.**
Follow any terms listed at the asterisk (*) on the Client Agreement.
- 08/31/2022 Financial Statements
- Complete required fields in PandaDoc with signature included and click the Finish button in the top righthand corner to return to our office.

NEW We can review your _____ with you, via a Zoom call if helpful to you.

As a client of Sullivan & Company, CPAs, you receive an Electronic Mailbox. The best way to send documents to us and receive documents is through this Electronic Mailbox. Other than this Electronic Mailbox, First Class Mail is always available.

Remarks: _____

Call with questions, or if you want our comments. (301) 657-8080

Signed: *Paul Sullivan*
Jane Huserova

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis

As of August 31, 2022

	Aug 31, 22
ASSETS	
Current Assets	
Checking/Savings	
Capital One Checking- NEW--8343	356,044
First Citizens Bank 2213	217,377
Total Checking/Savings	573,421
Accounts Receivable	
Accounts Receivable (A/R)	(1,300,000)
Total Accounts Receivable	(1,300,000)
Other Current Assets	
PPP Loan Payments	177,067
Undeposited Funds	1,300,000
Total Other Current Assets	1,477,067
Total Current Assets	750,488
Fixed Assets	
Accum. Depreciation	(87,333)
Computers	34,279
Furnitures and Equipment	34,781
Leasehold Improvements E&M Inve	321,277
Printers	7,386
Total Fixed Assets	310,389
Other Assets	
Due from Employee	5,000
Loan E&M Investment	289,500
Total Other Assets	294,500
TOTAL ASSETS	1,355,378
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Payroll Liabilities	
401K Payable	3,600
Total Payroll Liabilities	3,600
Total Other Current Liabilities	3,600
Total Current Liabilities	3,600
Long Term Liabilities	
EIDL SBAD TREAS	147,100
Total Long Term Liabilities	147,100
Total Liabilities	150,700
Equity	
Capital	20,000
Distributions Mohamed	(327,815)
Retained Earnings	859,469
Net Income	653,023
Total Equity	1,204,678
TOTAL LIABILITIES & EQUITY	1,355,378

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statement of Revenues and Expenses - Tax Basis
For the Period Ended August 31, 2022

	Jan - Aug 22	% of Income
Ordinary Income/Expense		
Income		
Service Revenues	8,298,628	100%
Total Income	8,298,628	100%
Cost of Goods Sold		
Direct Wages	1,159,814	14%
Subcontractors - COS	5,836,029	70%
Total COGS	6,995,843	84%
Gross Profit	1,302,786	16%
Expense		
Accounting	9,886	0%
Advertising	4,300	0%
Auto Expenses	4,167	0%
Bank & Merchant Fees	635	0%
Depreciation Expense	16,481	0%
Dues & Subscriptions	2,023	0%
Insurance	27,168	0%
Legal & Professional Fees	5,987	0%
Meals Business	425	0%
Office Expenses	25,030	0%
Parking	860	0%
Payroll Service Fees	4,588	0%
Pension Expense	1,732	0%
Rent or Lease	171,040	2%
Repair & Maintenance	50,577	1%
Salaries and Wages, Other	62,812	1%
Salary, Officer	111,600	1%
Software	16,396	0%
Taxes & Licenses	123,037	1%
Telephone Expenses	8,947	0%
Travel	852	0%
Utilities	1,220	0%
Total Expense	649,762	8%
Net Ordinary Income	653,023	8%
Net Income	653,023	8%

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: Mohamed Matope

Date: 2/20/24

Quality One Care Home Health, Inc.

The following items are enclosed:

E-file authorization form(s) for signature and tax returns for review. E-file authorization form(s) and tax returns have been placed in your portal. You should review the tax returns before returning signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:

- a. Return through DocuSign c. Upload back into your portal
b. Mail to our office via First Class Mail

Tax report(s) that cannot be filed electronically and must be filed on paper with instructions for filing. Follow the instructions attached. Copy(ies) of your tax report(s) have been placed in your portal.

Client Agreement and/or Engagement Letter. Sign via **DocuSign, mail, fax, or upload to your Portal**. Follow any terms listed at the asterisk (*) on the Client Agreement.

Complete required fields in DocuSign by agreeing to sign electronically. Click each sign tag and follow the instructions to add your electronic signature where required to sign or initial. Confirm your signature by clicking FINISH.

12/31/23 Financial Statements _____

We can review _____ with you. Please call our office to schedule.

As a client of Sullivan & Company, CPAs, you receive a secure client portal. The best way to send documents to us and to receive documents is through this portal. To access the portal: **Go to www.eSullivan.net -> Client Portal. Enter your email address as username, and password. Open the applicable folder once you have logged in.**

Remarks: _____

Call with questions, or if you want our comments. (301) 657-8080

Signed: *Paul Sullivan*
Jane Huserova

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis

As of December 31, 2023

	Dec 31, 23
ASSETS	
Current Assets	
Checking/Savings	
Capital One Checking- NEW--8343	1,411,769
First Citizens Bank 2213	9,994
Total Checking/Savings	1,421,764
Accounts Receivable	
Accounts Receivable (A/R)	(1,300,000)
Total Accounts Receivable	(1,300,000)
Other Current Assets	
PPP Loan Payments	101,117
Prepaid Payroll Taxes	3,086
Undeposited Funds	1,300,000
Total Other Current Assets	1,404,204
Total Current Assets	1,525,967
Fixed Assets	
Accum. Depreciation	(130,177)
Computers	34,279
Furnitures and Equipment	34,781
Leasehold Improvements E&M Inve	342,277
Printers	7,386
Total Fixed Assets	288,546
TOTAL ASSETS	1,814,513
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Payroll Liabilities	
401K Payable	2,908
Health Insurance	1,891
Total Payroll Liabilities	4,800
Total Other Current Liabilities	4,800
Total Current Liabilities	4,800
Long Term Liabilities	
EIDL SBAD TREAS	147,100
Total Long Term Liabilities	147,100
Total Liabilities	151,900

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis
As of December 31, 2023

	<u>Dec 31, 23</u>
Equity	
Capital	20,000
Distributions Mohamed	(17,367)
Retained Earnings	1,425,397
Net Income	<u>234,584</u>
Total Equity	<u>1,662,613</u>
TOTAL LIABILITIES & EQUITY	<u><u>1,814,513</u></u>

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

Quality One Care Home Health Inc
Statements of Revenues and Expenses - Tax Basis

For the Periods Ended December 31, 2023 and 2022

	<u>Jan - Dec 23</u>	<u>Jan - Dec 22</u>	<u>% Change</u>
Ordinary Income/Expense			
Income			
Service Revenues	16,482,073	13,840,361	19%
Total Income	16,482,073	13,840,361	19%
Cost of Goods Sold			
Direct Wages	2,216,891	1,751,452	27%
Subcontractors - COS	12,437,863	9,517,067	31%
Total COGS	14,654,754	11,268,518	30%
Gross Profit	1,827,319	2,571,843	(29)%
Expense			
Accounting	27,379	17,694	55%
Advertising	0	4,300	(100)%
Auto Expenses	8,222	7,260	13%
Bank & Merchant Fees	626	870	(28)%
CHARITY	5,000	0	100%
Depreciation Expense	21,603	37,722	(43)%
Dues & Subscriptions	3,280	3,337	(2)%
Education and Training Expenses	870	0	100%
Insurance	12,665	29,511	(57)%
Interest Expense	1,434	0	100%
Legal & Professional Fees	94,783	5,977	1,486%
Meals Business	0	425	(100)%
Office Expenses	64,264	63,202	2%
Parking	690	1,250	(45)%
Payroll Service Fees	8,302	7,416	12%
Penalties	124	0	100%
Pension Expense	52,631	14,981	251%
Rent or Lease	258,216	244,073	6%
Repair & Maintenance	68,253	77,807	(12)%
Salaries and Wages, Other	363,327	348,760	4%
Salary, Officer	226,000	195,600	16%
Taxes & Licenses	227,864	191,148	19%
Telephone Expenses	18,701	12,968	44%
Travel	5,183	852	509%
Utilities	14,905	3,361	344%
Total Expense	1,484,322	1,268,513	17%
Net Ordinary Income	342,997	1,303,330	(74)%
Other Income/Expense			
Other Expense			
Maryland Income Taxes	108,413	95,480	14%
Total Other Expense	108,413	95,480	14%
Net Other Income	(108,413)	(95,480)	(14)%
Net Income	234,584	1,207,850	(81)%

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

FINANCIAL PROJECTIONS & STATEMENT OF ASSUMPTIONS

Anne Arundel County, Montgomery County, Prince George's County, Calvert County, Charles County, and St. Mary's County (Six-County Service Area)

The following financial assumptions support the projected revenues, expenses, and operating results presented in Table 6 for Quality One Care Home Health, Inc.'s proposed Medicare-certified Home Health Agency serving the Six-County service area. These projections are based on conservative, evidence-driven estimates that reflect FY 2023 MHCC utilization data, established regional reimbursement patterns, and realistic staffing and operational cost structures.

The assumptions demonstrate that the proposed project is financially feasible, sustainable, and consistent with the requirements of COMAR 10.24.16.08F. Each assumption corresponds directly to a revenue or expense category in Table 6 and reflects the expected clinical, operational, and payer-mix characteristics of the Six-County service area.

1. Reporting Basis

- The projections are presented on a **financial year basis (FY)** and in **current dollars**, consistent with MHCC financial reporting requirements.
- The projection period is FY 2026 (Year 1) through FY 2028 (Year 3).

2. Utilization and Volume Assumptions

- Service Area Demand: Projected visit volume is supported by FY 2023 MHCC utilization data for the Six-County service area, which reflects substantial existing home health utilization. QOC's Year 1 volume (1,050 visits) is conservatively projected at well below 1% of total regional utilization
- RN Productivity: Projected at 2.2–3.0 visits per day, aligning with industry standards and supporting the calculated FTEs in Table 5.
- Therapist Productivity: Projected at 2.0–2.5 visits per day, aligning with industry standards.
- HHA Productivity: Projected at 4–5 hours/day depending on case mix, reflecting typical utilization of home health aide services.

3. Revenue Assumptions (Payer Mix, Allowances, and Charity Care)

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Metric	Source / Basis of Assumption	Regulatory Alignment
Gross Patient Service Revenue (GPSR)	Based on projected visit volume and current Maryland Medicare and Medicaid reimbursement ceilings.	COMAR 10.24.16.08F(2)
Payer Mix	Aligns with FY 2023 MHCC Utilization Tables (payer mix and charity care indicators for the Six-County service area) confirming a Medicare-dominant population in the Six-County service area / greater DC–Maryland regional labor market (>70%).	COMAR 10.24.16.08C
Medicare Reimbursement	Based on CY 2024 Maryland-specific Home Health Prospective Payment System (HH PPS) payment levels, including the Six-County service area / greater DC–Maryland regional labor market CBSA wage index.	Consistent with actual realizable revenue experienced by comparable HHAs.
Medicaid Reimbursement	Based on Maryland Medicaid fee schedules in effect at submission.	Consistent with payment patterns of existing agencies.
Private-Pay Rates	Uses rates consistent with QOC's projected Private Pay Fee Schedule (Exhibit 3).	Rates are transparent and aligned with FY 2023 MHCC Utilization Tables regional averages.
Allowance for Bad Debt	Projected at approximately 0.6% of GPSR , reflecting organizational historical experience.	Consistent with statewide norms.
Contractual Allowances	Range from 22–24% of GPSR , calculated using the difference between gross charges and expected net PPS/fee-for-service reimbursement.	Consistent with standard adjustments for negotiated payer discounts and Medicare sequestration.
Charity Care	Projected at approximately 0.5% of GPSR . This amount meets or exceeds the minimal levels observed in the 6-County Region (FY 2023 MHCC Utilization Tables).	Consistent with QOC's commitment under COMAR 10.24.16.08E .

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Non-Operating Income	None projected , as QOC anticipates no grants, donations, or non-operating revenue during the projection period.	Supports a sustainable model based on core service operations.
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4. Expense Assumptions (Staffing, Overhead, and Fixed Costs)

Expense Category	Basis of Assumption	Detail
Salaries & Wages	Based on competitive market rates for the Six-County service area / greater DC–Maryland regional labor market. RN salaries are estimated at \$78,000–\$90,000 annually.	Consistent with recent experience of other Maryland HHAs.
Fringe Benefits	Calculated at 22–24% of salary expense.	Covers payroll taxes, insurance, and other standard employee benefits.
Contractual Services	Includes therapy, social work, billing/claims support, and EMR technical support. Based on prevailing per-visit/per-hour rates.	Expenses are aligned with projected utilization and productivity.
Supplies	Estimated at \$6,000–\$12,000 annually, depending on volume. Covers nursing supplies (wound care, IV), PPE, and general clinical supplies.	Increases proportionally with service volume.
Administrative Overhead	Includes rent, utilities, insurance, recruiting, mileage, and IT support.	Increases proportionally with volume.
Bank Fees/Merchant Fees	Projected at \$75–\$100 per month, covering payroll processing and billing transactions.	Reflects non-clinical operating costs.
Accreditation or Dues	Projected at \$4,500 annually, covering Joint Commission renewal, industry memberships, and regulatory updates.	Reflects ongoing compliance requirements.
Training & Education	Budgeted at \$2,000 annually, covering initial orientation, annual competency, and clinical CE.	Consistent with state training expectations.

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Depreciation	Applied using straight-line depreciation over 5 years for office equipment, IT hardware, and capitalized EMR costs.	Standard accounting practice for fixed assets.
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EXHIBIT 3

Fees, Charges, and Time Payment Plan

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS
Fee Schedule
Time Payment Plan Policy
Financial Accessibility and Billing Policy

Quality One Care Home Health, Inc. (QOC) is committed to ensuring financial accessibility for all clients served. This exhibit provides QOC's fee disclosure approach and projected private-pay fee schedule, along with QOC's Time Payment Plan Policy as required by COMAR 10.24.16.08D. Consistent with QOC's mission and Maryland regulatory standards, QOC will not deny medically necessary services based on inability to pay and will offer time payment plans for patient responsibility balances.

Clients may also apply for charity care and sliding fee scale assistance as described in

Exhibit 4 — Charity Care and Sliding Fee Scale Policy.

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TIME PAYMENT PLAN POLICY

PURPOSE

The purpose of this policy is to ensure that all clients of Quality One Care Home Health, Inc. (QOC) are informed of available payment options and are provided reasonable means to pay for home health services if they are unable to remit full payment at the time services are rendered.

This policy supports compliance with COMAR 10.24.16.08D, which requires applicants to disclose fees and provide mechanisms for clients to arrange time payments.

POLICY STATEMENT

QOC is committed to providing transparency and fairness in billing practices.

- All fees will be disclosed to clients and families at the time of the initial assessment and prior to the initiation of services.
- Clients unable to make full payment may arrange time-payment plans through structured installment or deferred payments.
- No client shall be denied medically necessary services solely due to inability to make immediate payment.
- A written copy of this policy shall be submitted to the Maryland Health Care Commission (MHCC) and provided to each client upon admission.

SCOPE

This policy applies to all clients receiving home health services under Quality One Care Home Health, Inc. (QOC), including those covered by Medicare, Medicaid, private insurance, managed care organizations, and self-pay arrangements.

It governs all QOC personnel involved in client financial processes, including billing staff, clinical intake staff, financial counselors, administrators, and managers responsible for patient admissions, care coordination, or revenue-cycle operations.

This policy also applies to any contracted service providers or partner agencies acting on behalf of QOC in the delivery or billing of home health services. All individuals under this policy are responsible for ensuring consistent communication of service rates, payment options, and client

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financial rights in accordance with COMAR 10.24.16.08D and QOC's Financial Accessibility and Billing Policy.

PROCEDURES

The following procedures establish how Quality One Care Home Health, Inc. (QOC) implements this policy to ensure consistent communication of service fees and payment options to every client. QOC staff are responsible for explaining fees, documenting client acknowledgment, and assisting clients in arranging payment plans when needed. These procedures apply at every stage of admission and continue through the billing and follow-up process to maintain transparency and compliance with COMAR 10.24.16.08D.

➤ Fee Disclosure

- 1) At the time of admission or initial assessment, clients and families will receive a written fee schedule detailing the following:
 - a) Service rates (per-visit charges)
 - b) Payor options (insurance, Medicare, Medicaid, private pay)
 - c) Available payment arrangements, including the time-payment plan
- 2) Staff will review payment options verbally and answer client questions before services begin.
- 3) Clients will sign a Fee Disclosure and Payment Options Acknowledgment Form, which will be filed in their financial record.

➤ Eligibility for Time Payment Plan

- 1) Clients may request a time-payment plan if they demonstrate inability to pay in full at the time of service.
- 2) Eligibility is determined by the Billing Specialist or Administrator based on client discussion and documented financial need.
- 3) No credit checks or collateral requirements are imposed.
- 4) Participation in a payment plan does not affect eligibility for insurance or charity care consideration under separate policy

➤ Payment Plan Terms

Quality One Care Home Health, Inc. (QOC) offers structured and flexible payment plans designed to accommodate clients who are unable to make full payment at the time

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services are rendered. Each plan is established through mutual agreement between the client and QOC's billing department, ensuring clarity, fairness, and transparency in all financial arrangements. The following terms outline the standard structure, calculation, and documentation requirements for all time-payment agreements.

- 1) The standard payment period will not exceed six (6) months, unless an extension is approved by the Administrator.
- 2) Monthly installment amounts are calculated by dividing the total balance by the number of months in the plan.
- 3) Payment plans are interest-free and carry no administrative fees.
- 4) Each agreement must include:
 - a) Client name and account number
 - b) Services covered and total amount owed
 - c) Payment schedule (amounts and due dates)
 - d) Signatures of client (or responsible party) and QOC billing representative
- 5) Clients receive a copy of the signed agreement, and QOC retains the original in the billing file.
- 6) Accounts in good standing under an active time payment plan will not be referred to collections.

➤ **Financial Counseling and Assistance**

Quality One Care Home Health, Inc. (QOC) provides free financial counseling to all clients as part of its commitment to financial transparency and accessibility. A designated Financial Counselor assists clients in reviewing insurance coverage, estimating expected out-of-pocket costs, and identifying appropriate payment options.

The counselor also helps determine eligibility for Medicaid, Medicare, or other financial assistance programs and works with clients to establish or modify payment plans as needed. All financial counseling interactions and recommendations are documented in the client's admission record to ensure continuity and accountability.

➤ **Review and Adjustment of Payment Plans**

Clients who experience financial hardship may request a review of their existing payment plan at any time. Upon submission of an updated financial disclosure, Quality One Care Home Health, Inc. (QOC) may extend or modify the payment schedule to accommodate the client's circumstances. All proposed adjustments must receive approval from the

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Administrator and be signed by both the client and QOC's billing representative. Revised agreements are documented and securely retained in the client's billing file to ensure accurate recordkeeping and compliance.

➤ **Charges & Reimbursements**

Quality One Care Home Health, Inc. (QOC) will provide written disclosure of applicable fees during the admission process. QOC will bill private-pay/self-pay clients in accordance with the projected private-pay fee schedule provided in Exhibit 3B and will offer time payment plans consistent with QOC policy and applicable regulations.

For Medicare, Medicaid, and managed care plans, QOC will bill and be reimbursed in accordance with applicable payer fee schedules, contractual rates, coverage requirements, and regulatory standards. Patient responsibility amounts (e.g., co-payments, deductibles, and non-covered services) will be communicated to clients as part of the admission process, and clients may request time payment plans for balances due.

➤ **Confidentiality and Data Protection**

All financial and billing information, including payment plans, shall be treated as confidential and maintained in compliance with HIPAA and QOC's Privacy Policy. Access to such information is restricted to authorized administrative and billing staff only.

➤ **Oversight and Quality Assurance**

The Administrator or designee will conduct quarterly reviews of all active payment plans to ensure compliance with this policy, fair and consistent application, and client satisfaction. All findings from these reviews will be documented in the agency's Financial Accessibility Audit Report, which serves as a record of internal monitoring activities. Any identified discrepancies or noncompliance issues are promptly addressed and corrected within 30 days, ensuring continuous adherence to Quality One Care Home Health, Inc.'s financial accessibility standards and MHCC regulatory requirements.

➤ **Policy Review and Revision**

QOC Quality One Care



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This policy will be reviewed annually by the Administrator and updated as needed to maintain compliance with MHCC standards, COMAR 10.24.16.08D, and industry best practices. Any revisions will be submitted to MHCC as appropriate following administrative approval.

➤ **Staff Responsibilities**

The successful implementation of this policy relies on clear staff roles and coordination. The Intake Nurse or Care Coordinator is responsible for discussing fees and payment options with the client and family during the initial assessment. The Billing Specialist evaluates client eligibility, prepares payment plan documents, and monitors payment activity to ensure timely follow-up. The Financial Counselor assists clients in understanding their financial options, reviews insurance and assistance program eligibility, and provides ongoing support throughout the payment process.

The Administrator oversees the program by approving exceptions, reviewing the policy annually, and ensuring compliance reporting to maintain alignment with MHCC and COMAR requirements.

➤ **Documentation and Record Retention**

Quality One Care Home Health, Inc. (QOC) maintains complete and accurate records of all time-payment agreements and related correspondence to ensure accountability and compliance. Signed copies of payment plans are securely stored in each client's billing file, both electronically and in hard copy, for a minimum of five (5) years following resolution of the account. Access to these records is restricted to authorized administrative and billing personnel. QOC conducts annual internal audits to verify documentation accuracy, confirm adherence to policy requirements, and identify opportunities for process improvement.

➤ **Compliance Statement**

Quality One Care Home Health, Inc. (QOC) affirms that this Time Payment Plan Policy is fully compliant with the requirements of COMAR 10.24.16.08D. The policy ensures that all clients receive clear, written information regarding service fees and available payment options before services are rendered, in accordance with Maryland Health Care Commission standards. It establishes a fair and accessible mechanism for clients to arrange installment or deferred payments without discrimination, penalty, or interruption.

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of care. Through this policy, QOC demonstrates its ongoing commitment to financial transparency, client protection, and equitable access to home health services for all individuals within its service area.

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**FEE DISCLOSURE AND PAYMENT OPTIONS
ACKNOWLEDGMENT FORM**

Client Name: _____

Client DOB: _____ **Medical Record # (if available):** _____

Client Address: _____

Phone: _____ **Email (optional):** _____

Responsible Party (if applicable): _____

Relationship: _____ **Phone:** _____

Date of Admission / Start of Care: _____

1. Fee Disclosure Acknowledgment

I acknowledge that Quality One Care Home Health, Inc. (QOC) has provided me with written information regarding applicable fees and billing practices for home health services, including:

- Projected Private-Pay Fee Schedule** (if applicable)
- Explanation of **Medicare / Medicaid / Managed Care billing and reimbursement**
- Explanation of potential **patient responsibility amounts**, including co-payments, deductibles, coinsurance, and non-covered services (if applicable)

I understand that QOC will provide written disclosure of applicable fees during the admission process and will answer questions regarding charges, coverage, and billing practices.

2. Time Payment Plan Option

I acknowledge that QOC offers **time payment plans** for balances due and that:

- I may request a time payment plan if I am unable to pay my balance in full at the time services are rendered.
- Payment plans are offered **without interest** and **without administrative fees**.
- No credit check or collateral is required.

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- I **do not** wish to request a time payment plan at this time.
- I **may request** a time payment plan in the future if needed.

3. Financial Counseling and Assistance

I acknowledge that QOC offers **free financial counseling** to support clients in understanding:

- Insurance coverage (if applicable)
- Expected out-of-pocket costs
- Available payment options and payment plan arrangements
- Financial assistance options (including charity care/sliding fee scale if applicable)

4. Charity Care and Sliding Fee Scale Option

I acknowledge that QOC provides information regarding financial assistance options and that I may request information or apply for **charity care and/or sliding fee scale assistance** if I believe I may qualify.

- I **request** information about charity care/sliding fee scale.
- I **do not** request information at this time.

5. Client Rights and Non-Denial of Care

I understand that **no client will be denied medically necessary home health services solely due to inability to pay.**

6. Questions / Contact Information

If I have questions regarding fees, billing, payment options, or financial assistance, I may contact:

Billing Specialist / Financial Counselor

Phone: _____ Email: _____

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Acknowledgment and Signature

I certify that I have received and reviewed information regarding fees, billing practices, and payment options, and I have had the opportunity to ask questions.

Client/Responsible Party Signature: _____

Printed Name: _____

Date: _____

QOC Staff Member Signature: _____

Printed Name / Title: _____

Date: _____

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HHA PROJECT
Projected Private-Pay Fee Schedule

Proposed Home Health Agency Service Area: Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties, Maryland

OVERVIEW

Quality One Care Home Health, Inc. (QOC) has developed the following projected private-pay fee schedule using market comparables and data reported by the Maryland Health Care Commission (MHCC), including discipline-level utilization and average cost-per-visit information reported in the MHCC Home Health Utilization Tables for Fiscal Year 2023.

These projected rates apply to **private-pay/self-pay clients**. For Medicare, Medicaid, and managed care plans, QOC will bill and be reimbursed in accordance with applicable payer fee schedules, contractual rates, and regulatory requirements.

All clients will receive written notice of applicable rates during the admission process, consistent with **COMAR 10.24.16.08D** and QOC’s Time Payment Plan Policy.

Projected Private-Pay Fee Schedule

Service Type (Per Visit)	Projected Fee
Skilled Nursing	\$225
Physical Therapy	\$200
Occupational Therapy	\$200
Speech Therapy	\$200
Medical Social Work	\$375
Home Health Aide	\$175

Benchmark Reference

MHCC Home Health Utilization Tables FY 2023 — **Table 9: Total Visits and Average Cost Per Visit by Discipline and Home Health Agency** (six-county region) and Maryland market comparables.

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Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

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Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

Notes

1. These projected private-pay rates are intended for self-pay/private-pay clients and are reviewed annually following publication of MHCC Home Health Utilization Tables and internal review by QOC administration.
2. Medicare/Medicaid and managed care reimbursement is governed by payer rules and contractual rates.
3. Rates will be disclosed at admission, and QOC will offer time payment plans consistent with QOC policy and COMAR requirements.
4. This Projected Private-Pay Fee Schedule demonstrates that QOC's projected private-pay rates are reasonable, transparent, and supported by MHCC-reported utilization and cost-per-visit benchmarks and Maryland market comparables.

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FINANCIAL ACCESSIBILITY AND BILLING POLICY

PURPOSE

The purpose of this policy is to ensure that Quality One Care Home Health, Inc. (QOC) maintains transparent, fair, and accessible billing practices for all clients, consistent with Maryland Health Care Commission (MHCC) standards and applicable regulations. This policy establishes QOC's procedures related to fee disclosure, client financial assistance options, billing communications, collections practices, and financial accessibility protections.

This policy supports compliance with **COMAR 10.24.16.08D (Fees and Time Payment Plan)** and **COMAR 10.24.16.08E (Charity Care and Sliding Fee Scale)**.

POLICY STATEMENT

QOC is committed to ensuring that all clients receive clear information regarding fees, billing practices, and available financial assistance options before the initiation of services and throughout the episode of care.

QOC will:

- **Disclose applicable fees at admission** and provide written notice of available financial options.
- Offer **time payment plans** for client financial responsibility balances consistent with QOC's Time Payment Plan Policy.
- Provide **charity care and sliding fee scale assistance** consistent with QOC's Charity Care and Sliding Fee Scale Policy.
- Ensure that **no client is denied medically necessary home health services solely due to inability to pay**.
- Maintain billing and collection practices that are fair, non-discriminatory, and consistent with client rights, privacy requirements, and applicable regulations.

SCOPE

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This policy applies to all QOC clients receiving home health services, including those covered by Medicare, Medicaid, private insurance, managed care organizations, and private-pay/self-pay arrangements.

This policy applies to all QOC personnel involved in:

- Admissions and intake
- Fee disclosure and financial counseling
- Billing and revenue-cycle management
- Client communications regarding balances
- Time payment plan administration
- Charity care and sliding fee scale screening and processing

This policy also applies to any contracted service providers or partner agencies that perform billing-related functions on behalf of QOC.

DEFINITIONS

- **Client Financial Responsibility:** Any amount for which the client is responsible, including co-payments, deductibles, coinsurance, and non-covered services.
- **Private-Pay / Self-Pay:** Services billed directly to a client without third-party payer coverage.
- **Time Payment Plan:** A structured installment arrangement allowing a client to pay balances due over time consistent with QOC policy.
- **Charity Care / Sliding Fee:** Financial assistance provided to eligible clients consistent with QOC charity care and sliding fee scale policy.

PROCEDURES

1. Fee Disclosure and Financial Counseling at Admission

QOC will provide each client (and/or authorized representative) written notice of:

- Applicable service fees (including the private-pay fee schedule where applicable)
- Expected payer coverage, if known
- Client financial responsibility amounts (when applicable)
- Time payment plan availability
- Charity care and sliding fee scale availability (if applicable)

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Fee disclosure will occur during the admission process, and QOC staff will provide a verbal explanation of payment options and answer client questions prior to initiation of services.

Clients will sign a **Fee Disclosure and Payment Options Acknowledgment Form**, which will be retained in the client's financial record.

2. Billing Practices and Claims Submission

QOC will bill and be reimbursed according to applicable payer requirements:

- **Medicare / Medicaid / Managed Care:** QOC will bill and be reimbursed in accordance with payer fee schedules, contractual rates, coverage requirements, and applicable regulatory standards.
- **Private-Pay / Self-Pay:** QOC will bill private-pay clients in accordance with the **Projected Private-Pay Fee Schedule** and will disclose charges in advance.

QOC will submit claims accurately and timely and will provide clients with itemized statements upon request.

3. Patient Responsibility Amounts

When applicable, QOC will communicate patient responsibility amounts (e.g., co-payments, deductibles, non-covered services) as early as possible and prior to the provision of non-covered services.

Clients may:

- Request financial counseling
- Apply for charity care/sliding fee assistance if eligible
- Request a time payment plan for balances due

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4. Time Payment Plans

QOC offers time payment plans to clients unable to remit full payment at the time services are rendered. The time payment plan process is governed by QOC's **Time Payment Plan Policy**.

Key principles include:

- No interest or administrative fees
- No credit checks or collateral requirements
- Ability to request hardship modification
- Written agreement and documentation requirements

5. Charity Care and Sliding Fee Scale Assistance

QOC will provide charity care and sliding fee scale assistance consistent with QOC's Charity Care and Sliding Fee Scale Policy. Staff will provide information and referral to charity care screening during admission and/or upon request.

Charity care determinations and procedures will be documented in accordance with QOC policy and MHCC requirements.

6. Billing Statements, Communications, and Client Support

QOC will:

- Provide billing statements that are clear and understandable
- Offer a designated point of contact (Billing Specialist or Financial Counselor) for billing questions
- Provide dispute resolution pathways for billing concerns
- Document billing communications and dispute outcomes in the client's account file

7. Collections Practices and Protections

QOC maintains fair and non-discriminatory collections practices.

- QOC will not pursue collection activity for balances under active review for charity care eligibility or for clients actively engaged in a time payment plan in good standing.
- Accounts in good standing under an active time payment plan will not be referred to collections.

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- If payments are missed, QOC will provide written notice and an opportunity to cure prior to escalation.
- QOC will not use aggressive or coercive collection practices.

8. Non-Discrimination / No Denial of Care

QOC affirms that **no client will be denied medically necessary home health services solely due to inability to pay.**

Financial counseling, time payment plans, and charity care/sliding fee assistance will be provided without discrimination based on race, color, national origin, age, sex, disability, religion, or any other protected status.

9. Privacy and Confidentiality

All financial and billing information is confidential and will be maintained in compliance with HIPAA and QOC privacy policies. Access to billing and financial records is limited to authorized personnel only.

STAFF RESPONSIBILITIES

- **Intake Nurse / Care Coordinator:** Provide fee disclosure materials and explain payment options during admission.
- **Billing Specialist:** Prepares bills, manages payment plans, tracks balances, and handles billing questions.
- **Financial Counselor:** Provides counseling on insurance coverage, financial responsibility estimates, time payment plan support, and charity care referrals.
- **Administrator:** Oversees compliance, approves exceptions, and ensures implementation of policy requirements.

DOCUMENTATION AND RECORD RETENTION

QOC will maintain complete documentation related to:

- Fee disclosures and acknowledgments
- Billing statements and correspondence
- Payment plan agreements and modifications
- Charity care/sliding fee applications and determinations
- Dispute resolution documentation

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Records will be retained for a minimum of **five (5) years** following resolution of the account, consistent with QOC record retention standards.

OVERSIGHT, AUDIT, AND QUALITY ASSURANCE

The Administrator or designee will conduct periodic reviews of billing practices, payment plan implementation, and financial accessibility protections to ensure policy compliance. Findings will be documented and corrective actions implemented when needed.

COMPLIANCE

Quality One Care Home Health, Inc. (QOC) affirms that this Financial Accessibility and Billing Policy supports compliance with MHCC CON review standards and applicable regulatory requirements, including COMAR 10.24.16.08D and 10.24.16.08E. This policy ensures transparency in fees and billing practices, provides mechanisms for time payments and financial counseling, and reinforces QOC's commitment to equitable access to home health services.

EXHIBIT 4

Charity Care & Sliding Fee Scale Policy

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

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Health Equity & Charity Care Compliance Worksheet

Charity Care & Sliding Scale Policy

Charity Care & Financial Assistance Application Form

Sliding Fee Scale Tables

Sliding Fee Worksheet

Public Notice Signage

Federal FPL Detailed Guidelines 2025

Maryland FPL Detailed Guidelines 2025

HEALTH EQUITY & CHARITY CARE COMPLIANCE WORKSHEET

Applicant: Quality One Care Home Health, Inc. (QOC)

Project Type: Establishment of a Home Health Agency (HHA)

Jurisdictions Served: Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, & St. Mary’s Counties

Regulatory Reference: COMAR 10.24.16.08E – Charity Care and Sliding Fee Scale

COMAR STANDARDS	Quote from the policy	Section citation
<p>10.24.16.08E Charity Care and Sliding Fee Scale</p> <p>Each applicant for home health agency services shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to home health agency services regardless of an individual’s ability to pay and shall provide home health agency services on a charitable basis to qualified indigent and low-income persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:</p>		
<p>1.Determination of Eligibility for Charity Care and Reduced Fees.</p> <p>Within two business days following a client’s initial request for charity care services, application for medical assistance, or both, the home health agency shall make a determination of probable eligibility for medical assistance, charity care, and reduced fees, and communicate this probable eligibility determination to the client.</p>	<p>“QOC will make a probable eligibility determination within two business days of: (1) A request for charity care, (2) Submission of a financial assistance application, or (3) Submission of a Medical Assistance (Medicaid) application.”</p> <p>During the first contact or upon referral, QOC will assess family size, insurance status, household income, and financial resources to determine probable eligibility.”</p> <p>“Care will not be denied or delayed while an application is pending.”</p>	<p>QOC Charity Care Assessment & Financial Assistance Policy — Section V: Determination of Probable Eligibility</p> <p>QOC Charity Care & Discount Policy — Section VI: Application Process</p>

<p>2. Notice of Charity Care and Sliding Fee Scale Policies.</p> <p>Public notice and information regarding the home health agency’s charity care and sliding fee scale policies shall be disseminated, on an annual basis, through methods designed to best reach the population in the HHA’s service area, and in a format understandable by the service area population. Notices regarding the HHA’s charity care and sliding fee scale policies shall be posted in the business office of the HHA and on the HHA’s website, if such a site is maintained. Prior to the provision of HHA services, a HHA shall address clients’ or clients’ families concerns with payment for HHA services and provide individual notice regarding the HHA’s charity care and sliding fee scale policies to the client and family.</p>	<p>Public Notice Statement:</p> <p>“Quality One Care Home Health, Inc. (QOC) will make home health care available to all residents of its service area... Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. Probable eligibility will be determined within two business days.”</p> <p>“QOC will make this policy available: at admission, during financial counseling, in patient packets, on the website, and in publicly accessible office areas, in English, Spanish, and other languages.”</p>	<p>QOC Charity Care Public Notice — Public Notice Statement</p> <p>QOC Charity Care & Discount Policy — Section VIII: Communication of Policy</p> <p>QOC Sliding Fee Scale Tables — Posting Requirement Section</p>
<p>3. Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy.</p> <p>Each HHA’s charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income clients who do not qualify for full charity care but are unable to bear the full cost of services.</p>	<p>Sliding Fee Scale:</p> <p>0–200% FPL: 100% charity care (free) 201–250% FPL: 75% discount 251–300% FPL: 50% discount 301–350% FPL: 25% discount >350% FPL: case-by-case hardship / time payment plan</p> <p>“QOC provides charity care (free care) to patients with income 0–200% FPL and discounted care based on the sliding fee scale for patients 201–350% FPL, with case-by-case hardship consideration above 350% FPL.</p>	<p>QOC Sliding Fee Scale Tables — Income Eligibility & Discount Table</p> <p>QOC Charity Care & Discount Policy — Section V: Sliding Fee Scale</p> <p>QOC Time Payment Plan Policy — Payment Plan Terms</p>

<p>4. Policy Provisions.</p> <p>An applicant proposing to establish a home health agency or expand home health agency services to a previously unauthorized jurisdiction shall make a commitment to, at a minimum, provide an amount of charity care equivalent to the average amount of charity care provided by home health agencies in the jurisdiction or multi-jurisdictional region it proposes to serve during the most recent year for which data is available. The applicant shall demonstrate that:</p> <p>(a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and</p> <p>(b) It has a specific plan for achieving the level of charity care to which it is committed.</p>	<p>“QOC will not deny, delay, or discontinue medically necessary care based on inability to pay.”</p> <p>“QOC does not discriminate in the provision of charity care... based on race, ethnicity, national origin, gender, age, disability, immigration status, insurance status, or any protected characteristic.”</p> <p>“QOC provides charity care (free care) to patients with income 0–200% FPL and discounted care based on the sliding fee scale for patients 201–350% FPL, with case-by-case hardship consideration above 350% FPL.</p> <p>“Probable eligibility will be determined within two business days... Discounts may be applied retroactively for up to 90 days.”</p> <p>“Utilization of charity care will be reviewed to ensure access... Policy effectiveness will be reviewed annually.”</p>	<p>QOC Charity Care & Discount Policy — Sections II, IX & XII</p> <p>QOC Charity Care Assessment & Financial Assistance Policy — Section V</p>
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CHARITY CARE & SLIDING FEE SCALE POLICY

Quality One Care Home Health, Inc. (QOC) is committed to ensuring that all individuals, regardless of income, insurance status, or ability to pay, have access to medically necessary home health services. This policy complies with **COMAR 10.24.16.08E**, Maryland Health Care Commission (MHCC) standards, and federal nondiscrimination requirements.

QOC provides charity care, discounted services, and flexible payment arrangements to eligible clients based on verified financial need. Financial hardship will never delay or prevent the delivery of clinically necessary services.

1. Eligibility for Charity Care

QOC determines eligibility for charity care based on **household income, family size**, and the **Federal Poverty Level (FPL)** guidelines.

Charity care eligibility includes:

- Clients with **income at or below 200% FPL** are eligible for **100% charity care**.
- Clients with **documented inability to pay**, even if above FPL guidelines, may receive charity consideration based on special circumstances.
- Eligibility is based on income verification, which may involve pay stubs, tax returns, benefit statements, or a written attestation when documentation is unavailable.

QOC makes a **probable eligibility determination within two business days**, as required by COMAR.

2. Sliding Fee Scale Discounts

Clients who do not qualify for full charity care may receive discounted services under QOC's sliding fee scale:

- **0–200% FPL:** 100% charity care (free)
- **201–250% FPL:** 75% discount
- **251–300% FPL:** 50% discount
- **301–350% FPL:** 25% discount
- **>350% FPL:** case-by-case hardship / time payment plan

These discounts apply to all covered home health services billed directly by QOC.

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3. Time Payment Plan

For clients who qualify for discounted care but cannot pay their portion upfront, QOC provides a **Time Payment Plan**, which:

- Allows monthly interest-free installments
- Offers extensions based on documented hardship
- Provides clear written agreements outlining responsibilities
- Ensures no delay, denial, or reduction of services due to inability to pay

The Time Payment Plan is detailed in **Exhibit 3A – Time Payment Plan Policy**.

4. Notice of Charity Care & Discount Programs

QOC ensures that clients and the community receive clear and accessible notice of financial assistance programs:

- Notices are posted in QOC's business office.
- Information is published annually on the agency website.
- Individual written notice is provided at admission.
- Staff review financial assistance options with clients and families as part of the intake and billing process.
- Interpreter services are available for clients with limited English proficiency.

These measures comply with **COMAR 10.24.16.08E(2)**.

5. Application & Documentation Process

QOC uses a standardized financial-assessment form to determine eligibility.

The process includes:

- Initial screening upon request or at admission
- Written probable eligibility determination within two business days
- Final determination within ten business days once documentation is complete
- Documentation reviewed by QOC's Financial Counselor or designee

Clients may request assistance completing forms and gathering documents.

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6. Appeals

Clients who disagree with a charity care or discount determination may appeal. Appeals are reviewed by the Clinical Director or a designated administrative officer. Decisions are made within 10 business days and communicated in writing.

7. Recordkeeping and Confidentiality

All financial information is maintained securely and used solely to determine eligibility for reduced fees, charity care, or payment arrangements.

QOC follows HIPAA and Maryland confidentiality standards.

8. Policy Review

QOC reviews this policy annually to ensure compliance with:

- COMAR 10.24.16
- MHCC standards
- Federal poverty guidelines
- Internal quality improvement processes

Revisions are made as needed.

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**CHARITY CARE & FINANCIAL ASSISTANCE
APPLICATION FORM**

This application is used to determine eligibility for Charity Care, Sliding-Scale Discounts, or Time-Payment Arrangements under the Quality One Care Home Health, Inc. (QOC) Charity Care and Financial Assistance Program.

Applicants must complete all sections and provide required documentation. Incomplete applications may delay processing.

SECTION 1 — APPLICANT INFORMATION

Name: _____

Date of Birth: ____ / ____ / ____

Social Security Number: — _____

Home Address: _____

City _____ State _____ ZIP _____

Phone (Home): _____ **Phone (Cell):** _____

Email: _____

Marital Status: Single Married Separated Divorced Widowed

Preferred Language: _____

Interpreter Needed: Yes No

Employer: _____

Employer Address: _____

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SECTION 2 — HOUSEHOLD MEMBERS

List all members of your household, including yourself.

Name	Age	Relationship	Income (Monthly)

SECTION 3 — MEDICAL ASSISTANCE / INSURANCE STATUS

Have you applied for Medicaid/Medical Assistance? Yes No

If yes, **Date Applied:** ____ / ____ / ____

Status: Pending Approved Denied

Do you receive any state or county assistance? Yes No

If Yes, Describe:

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SECTION 4 — MONTHLY INCOME

List gross monthly income for all sources. Attach documentation for each applicable item.

Income Source	Monthly Amount
Employment	_____
Retirement/Pension	_____
Social Security	_____
Disability	_____
Public Assistance	_____
Unemployment	_____
Veterans Benefits	_____
Alimony	_____
Rental Income	_____
Self-Employment	_____
Other: _____	_____

Total Monthly Income: _____

SECTION 5 — ASSETS

Liquid Assets

Asset Type	Current Balance
Checking Account	_____
Savings Account	_____
CDs / Bonds / Money Market	_____
Other Liquid Assets	_____

Total Liquid Assets: _____

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Other Assets

Asset Type	Approximate Value	Loan Balance
Home	_____	_____
Automobile (Make/Year): _____	_____	_____
Second Vehicle (Make/Year): _____	_____	_____
Additional Property	_____	_____

SECTION 6 — MONTHLY EXPENSES

Expense Type	Monthly Amount
Rent/Mortgage	_____
Utilities	_____
Car Payment(s)	_____
Credit Card(s)	_____
Insurance (Car/Health)	_____
Medical Expenses	_____
Food/Other	_____

Total Monthly Expenses: _____

Do you have unpaid medical bills? Yes No

If yes, for what service(s)? _____

If you already have a payment plan, **monthly payment amount:** _____

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SECTION 7 — DOCUMENTATION CHECKLIST

Please attach copies (not originals) of the following, when applicable:

- Last 3 months of pay stubs
- Employer income verification letter
- Last year’s tax return (if self-employed)
- 3 months of bank statements
- Social Security / pension award letters
- Public assistance or benefit letters
- Letter of support (if another person provides housing/food)
- Medicaid denial or approval letter (if applicable)

SECTION 8 — CERTIFICATION & SIGNATURE

I certify that the information provided in this application is accurate and complete. I understand that Quality One Care Home Health, Inc. may request additional information to determine eligibility. I agree to notify QOC of any changes to my financial situation within 10 days.

Applicant Signature: _____

Date: ____ / ____ / ____

Relationship to Patient/Client (if not applicant): _____

Submit completed application and documentation to:

Quality One Care Home Health, Inc.

RE: Client Financial Services Department

Address: 9221 Colesville Road, Silver Spring, MD 20910

Phone: 301-658-7141 / Fax: 301-658-2328

Email: info@qualityonecare.com

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SLIDING FEE SCALE TABLES

Effective Date: 2025

Based on the Federal Poverty Guidelines (FPG)

This Sliding Fee Scale is used to determine the level of financial assistance available to eligible clients of Quality One Care Home Health, Inc. (QOC). Discount levels are determined by household income and size, as verified through the QOC Financial Assistance Application.

INCOME ELIGIBILITY & DISCOUNT TABLE

All percentages refer to Federal Poverty Guideline (FPG) thresholds.

Household Income as % of FPG	Discount Level	Client Responsibility
0% – 200% of FPG	100% Discount (Full Charity Care)	\$0 owed
201% – 300% of FPG	75% Discount	25% of charges
301% – 350% of FPG	50% Discount	50% of charges
351% – 400% of FPG	25% Discount	75% of charges
Above 400% of FPG	Standard Charges Apply – Unless Financial Hardship is documented	May qualify for Time-Payment Plan or Special Hardship Review

HOUSEHOLD INCOME TABLE – 2025 FEDERAL POVERTY GUIDELINES

(Effective January 2025 — official HHS values)

Household Size	100% FPG	200% FPG	300% FPG	400% FPG
1	\$15,650	\$31,300	\$46,950	\$62,600
2	\$21,150	\$42,300	\$63,450	\$84,600
3	\$26,650	\$53,300	\$79,950	\$106,600
4	\$32,150	\$64,300	\$96,450	\$128,600
5	\$37,650	\$75,300	\$112,950	\$150,600
6	\$43,150	\$86,300	\$129,450	\$172,600
7	\$48,650	\$97,300	\$145,950	\$194,600
8	\$54,150	\$108,300	\$162,450	\$216,600

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For households larger than eight (8), add \$5,500 for each additional person at the 100% FPG level, then multiply accordingly for higher percentages. Values are updated each year when HHS issues new guidelines.

PROGRAM NOTES

- Determinations are based on **gross household income** and documentation submitted.
- Clients with **special financial hardship** may request individualized review.
- Discounts apply only to medically necessary home health services.
- Probable eligibility is determined within **two business days**, as required by Maryland law.

POSTING REQUIREMENT

This chart must be posted:

- In the QOC main office
- On the official website
- In all service intake areas
- Included in client admission packets

For questions or assistance, call QOC at 301-658-7141 or email info@qualityonecare.com.

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CHARITY CARE & SLIDING FEE SCALE WORKSHEET

This worksheet is used to determine a client's eligibility for **Charity Care, Sliding Fee Scale discounts**, or the **Time Payment Plan**. It supports compliance with **COMAR 10.24.16.08E**, which requires timely assessment and consistent application of financial-assistance criteria.

The worksheet is completed by QOC's Financial Counselor or designated staff at admission or upon client request.

1. Client Information

- Client Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
- Emergency Contact: _____

2. Household Information

- Total Household Income: \$ _____
- Number of People in Household: _____
- Income Documentation Provided:
 - Pay Stubs
 - Tax Return
 - Social Security/Benefit Letter
 - Employer Letter
 - Client Attestation (no documentation available)

3. Federal Poverty Level (FPL) Determination

- Applicable FPL for Household Size: \$ _____
- Income as % of FPL: _____ %

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- Is Income Verified?
 - Yes
 - No (explain): _____

4. Eligibility Determination (Select One)

A. Full Charity Care – 100% Discount

Approved: Household income \leq **200% FPL**

Approved: Special circumstances (explain):

Not Approved

B. Sliding Fee Scale Discounts

Based on verified household income as a percent of FPL:

FPL Range	Discount	Eligibility
201–250% FPL	75% Discount	<input type="checkbox"/> Yes <input type="checkbox"/> No
251–300% FPL	50% Discount	<input type="checkbox"/> Yes <input type="checkbox"/> No
301–350% FPL	25% Discount	<input type="checkbox"/> Yes <input type="checkbox"/> No
Above 350% FPL	Case-by-case hardship review	<input type="checkbox"/> Yes <input type="checkbox"/> No

If hardship review requested, explain:

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5. Time Payment Plan Eligibility

Clients who qualify for reduced fees but cannot pay remaining balances upfront may participate in QOC's Time Payment Plan (Exhibit 2).

- Does client need payment plan assistance?
 - Yes
 - No

If yes, proposed monthly payment: \$ _____

Length of Plan (months): _____

Any special conditions: _____

6. Probable Eligibility Determination

(Required within 2 business days per COMAR)

- Date of Initial Request: _____
- Date Probable Eligibility Determined: _____
- Probable Eligibility:
 - Full Charity Care
 - Discounted Care (Sliding Fee Scale)
 - Time Payment Plan
 - Not Eligible (reason): _____

Client Notified:

- In Writing
- Verbally
- Date Notified: _____

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7. Final Determination

(Completed within 10 business days of receiving full documentation)

- Final Eligibility Decision:
 - Full Charity Care
 - Sliding Fee Scale Discount
 - Time Payment Plan
 - Not Eligible
- Approved Discount Level (if applicable): _____%
- Effective Dates of Assistance: _____

Staff Completing Worksheet: _____

Title: _____

Signature: _____

Date: _____

8. Client Acknowledgment

I have received information on the Charity Care Policy, Sliding Fee Scale, and Time Payment Plan options and understand my responsibility to provide accurate financial information.

Client Signature: _____

Date: _____

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QOC Charity Care Public Notice

Quality One Care Home Health, Inc. (QOC) will make home health care available to all adult residents of its service area regardless of race, creed, gender, age, sexual orientation, national origin, or financial status. If insurance coverage is not available for reimbursement, patients or guarantors are responsible for payment. Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. Probable eligibility will be determined within two business days of a request for assistance or an application for Medical Assistance. Assistance amounts are based on Federal Income Poverty Guidelines. For information or applications, call 301-658-7141.

Sample Notice

NOTICE TO PATIENTS

This practice serves all patients regardless of ability to pay.

Discounts are offered based on family size and income.

Interpreter services are available at no cost.

For more information, contact our Intake/Billing Office at (301) 658-7141,
email info@qualityonecare.com, or visit www.qualityonecare.com.

Thank you.

AVISO PARA PACIENTES:

Este establecimiento de salud atiende a todos los pacientes independientemente de su capacidad de pago.

Se ofrecen descuentos según el tamaño de la familia y los ingresos.

Servicios de interpretación disponibles sin costo.

Para obtener más información, comuníquese con nuestra oficina al (301) 658-7141,
envíe un correo electrónico a info@qualityonecare.com, o visite www.qualityonecare.com.

Gracias.

EXHIBIT 5

Admissions & Discharge Policy

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS
Admissions & Discharge Policy
Admission Booklet



QOC Admission and Discharge Policy

I. PURPOSE

The purpose of this policy is to ensure that all patients referred to or receiving services from Quality One Care Home Health, Inc. (“QOC”) are admitted and discharged in a consistent, patient-centered, clinically appropriate, and legally compliant manner. This policy guides the full continuum of care, from referral to admission through discharge, to ensure:

- Equitable access to care
- High-quality, evidence-based service delivery
- Safe and efficient transitions between care settings
- Protection of patient rights
- Compliance with Medicare Conditions of Participation (42 CFR 484), COMAR 10.24.16.08, COMAR 10.24.01.08G(3), and Joint Commission standards

QOC is committed to serving **adult patients**, including those with **high-acuity or medically complex needs**, and will not refuse admission based on complexity, disability, or ability to pay. QOC may serve pediatric patients as clinically appropriate and based on staffing competencies and program capability.

II. SCOPE

This policy applies to:

- All clinical and administrative staff involved in the referral, intake, admission, care delivery, discharge, documentation, or coordination of services
- All patient populations (adult, pediatric, high-acuity, chronic, post-acute, palliative, etc.)
- All disciplines (RN, LPN, PT, OT, ST, MSW, Home Health Aide)
- All payer types (Medicare, Medicare Advantage, Medicaid, Medicaid Waiver, commercial insurance, workers’ compensation, private pay, charity care/discounted care)

III. POLICY STATEMENT

QOC will provide timely, appropriate, and patient-centered admission and discharge processes that:

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- Prioritize safety, quality, and continuity of care
- Ensure access to services regardless of ability to pay (see Exhibit 4 – Charity Care and Sliding Fee Scale Policy)
- Actively involve patients, families, and caregivers in all decisions
- Maintain compliance with all regulatory requirements
- Coordinate care with physicians, hospitals, and community providers
- Prevent inappropriate/unsafe discharge or abandonment of patients
- Support the highest possible clinical outcomes and patient satisfaction
- Begin discharge planning at admission and update throughout the episode of care
- Follow CMS and COMAR requirements for documentation and notification

IV. DEFINITIONS

Admission:

The formal acceptance of a patient for home health services based on medical necessity, physician order, eligibility, and agency capacity.

Discharge:

The completion or termination of home health services, either due to goal attainment, transition of care, patient choice, physician order, or specific clinical or safety reasons.

Interdisciplinary Team (IDT):

Registered Nurses, Licensed Practical Nurses, Physical Therapists, Occupational Therapists, Speech Therapists, Medical Social Workers, Home Health Aides, and administrative or clinical leadership collaborating on patient care.

Plan of Care (POC):

Comprehensive treatment plan ordered and approved by a physician in accordance with Medicare requirements (CMS Form 485 or electronic equivalent).

Homebound Status:

CMS criterion for Medicare patients indicating that leaving home requires considerable effort or assistance (not required for pediatric or certain Medicaid populations).

High-Acuity Patient:

A patient requiring complex clinical management (e.g., ventilator, tracheostomy, IV infusion, complex wound care, enteral feeding).

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Medically Necessary Services:

Services required to treat illness, injury, or disability, ordered by a physician, and provided by qualified clinicians.

Patient Rights:

The legal and ethical rights afforded to all patients, detailed in QOC's Patient Rights & Responsibilities Policy (provided at admission).

V. ADMISSION PRINCIPLES

QOC admits patients in a manner that ensures:

- Timely access to medically necessary care
- Patient and family involvement in decision-making
- Equitable access regardless of payor, diagnosis, disability, or complexity
- Clinical appropriateness and safety
- Compliance with physician orders and regulatory requirements
- Immediate initiation of discharge planning to ensure continuity of care

QOC will **not** refuse admission based solely on:

- High-acuity or complexity of condition
- Disability or cognitive impairment
- Age (including pediatric or geriatric)
- Ability or inability to pay (see Charity Care Policy)
- Payor type (including Medicaid, Medicare, and uninsured)
- Geographic location within approved service area (Frederick, Carroll, Washington, Allegany, Garrett Counties)

VI. ADMISSION CRITERIA

A patient will be admitted when **all of the following apply:**

1. Clinical Eligibility

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- The patient requires **skilled services** (nursing or therapy) as defined by CMS or payor
- The service is **medically necessary** to treat an illness or condition
- The patient's needs can be **safely met at home**
- The patient (or legal guardian) provides **informed consent**

2. Physician Involvement

- A **physician or allowed practitioner** (MD, DO, NP, PA) orders home health services
- The physician agrees to **review and sign the Plan of Care (POC)**
- The physician collaborates with QOC throughout the episode

3. Payor Eligibility

QOC accepts:

- Medicare
- Medicare Advantage
- Medicaid & Medicaid Waiver
- Commercial insurance
- Worker's compensation
- Private pay
- Veterans programs
- Charity care/discounted care (when eligible)

Inability to pay is NEVER a reason to deny admission.

4. Service Area

Patient must reside in one of the following six counties/jurisdiction from Maryland: Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties.

5. Homebound Status (Medicare-specific)

- Medicare patients must meet CMS homebound criteria unless exempt
- Pediatric, Medicaid waiver, or private insurance patients may not need to be homebound

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6. Agency Capability

QOC must have the qualified staff, equipment, and resources to meet patient's needs safely and effectively.

VII. SPECIAL POPULATIONS SERVED

A. High-Acuity Patients

QOC accepts medically complex patients requiring:

- Tracheostomy care
- Ventilator support (invasive or non-invasive)
- Enteral or parenteral feeding
- IV infusion therapy
- Complex wound care
- PICC/central line management
- Ostomy care
- Post-operative care
- Chronic disease management (CHF, COPD, diabetes, dementia, oncology, etc.)

B. Pediatric Patients

QOC admits infants, children, and adolescents with:

- Congenital or genetic disorders
- Neuromuscular or neurological impairments
- Tracheostomy or ventilator dependence
- Feeding tube or nutritional support

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- Failure to thrive
- Post-NICU/PICU transition
- Technology dependence or ongoing skilled needs

Pediatric admission includes:

- Consent from parent/legal guardian
- Collaboration with pediatric specialists or primary care provider
- Consideration of school or daycare coordination
- Age-appropriate safety and developmental assessment
- Inclusion of family training and education

C. Behavioral and Cognitive Considerations

QOC admits patients with cognitive or behavioral health conditions **when care can be delivered safely**.

QOC may involve social work, behavioral health providers, or caregivers as needed to ensure safety and cooperation.

VIII. REFERRAL & INTAKE PROCESS

QOC receives referrals from:

- Hospitals and discharge planners
- Skilled nursing and rehab facilities
- Physicians and specialists
- Case managers
- Medicaid waiver programs
- Insurance plans/managed care organizations
- Schools or pediatric programs
- Families or self-referrals

Intake Staff Responsibilities:

- Collect clinical information, demographics, and insurance details
- Confirm physician order or request one
- Screen for skilled need and appropriateness
- Verify service area eligibility

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- Identify urgency (routine vs. priority vs. same day)
- Communicate with clinical management for high-acuity cases
- Explain services, patient rights, and financial policies
- Initiate benefits verification and authorization

No patient will be denied admission due to incomplete paperwork at referral.

Intake staff will assist patients/families in gathering necessary documentation.

IX. CLINICAL REVIEW & APPROVAL

An RN or Clinical Director reviews every referral to determine:

- Clinical appropriateness
- Required discipline(s)
- Complexity and staffing needs
- Safety considerations
- Need for special equipment or supplies
- Any potential risk factors
- Need for interdisciplinary team collaboration

The **Director of Nursing** and/or **Administrator** must approve any high-acuity or unusual cases to ensure staffing and resource readiness.

X. RAPID ADMISSION & HOSPITAL COORDINATION

To support hospital throughput and reduce readmissions:

- Standard admission begins **within 48 hours** of referral
- **Same-day or next-day** start of care for urgent or high-priority patients
- QOC may conduct **hospital or facility pre-discharge visits**
- QOC collaborates directly with hospital case managers or physicians
- QOC accepts referrals **7 days/week**
- QOC maintains an **on-call nurse** for urgent clinical coordination

This rapid, flexible admission model supports MHCC goals for timely post-acute transitions.

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XI. INITIAL ASSESSMENT

A **comprehensive, in-home assessment** is performed by an RN or qualified therapist and includes:

- Physical exam and clinical status
- Functional, cognitive, and psychosocial assessment
- Medication reconciliation
- Pain and symptom management
- Fall risk evaluation
- Home safety and environmental review
- Social determinants of health (transportation, support, financial)
- Patient and caregiver education needs
- Cultural or language needs
- Emergency and contingency plans

For Medicare patients: OASIS assessment is completed as required.

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XII. PLAN OF CARE (POC)

Following assessment, the clinician develops a patient-centered Plan of Care that includes:

- Diagnoses and clinical goals
- Types and frequency of services
- Interventions and treatment plan
- Equipment, supplies, or technology needs
- Safety measures and caregiver training
- Discharge planning considerations
- Interdisciplinary coordination

The POC is:

- Reviewed, approved, and signed by the physician (CMS Form 485 or EHR equivalent)
- Reviewed every 60 days or sooner if the condition changes
- Updated based on patient progress and/or new orders



DISCHARGE POLICY

I. Discharge Planning

- Discharge planning starts **at admission** and is updated at every IDT review.
- The clinician discusses likely discharge goals, criteria, and needs with the **patient/caregiver and physician**; updates the plan of care as the condition evolves.
- Planning prioritizes **safety, continuity, patient goals/preferences, and timely transition** to the appropriate level of care.

II. Discharge Criteria

A patient may be discharged when one or more apply:

1. **Goals achieved / no further skilled need**
 - Wound closed; medication stabilized; therapy goals met.
2. **Maximum practical benefit reached**
 - Plateau despite appropriate interventions; transition to maintenance/outpatient.
3. **Patient choice / refusal / transfer**
 - Patient elects to stop services or move to another HHA/SNF/assisted living/hospice.
4. **Physician order to discontinue home health**
 - Document order and clinical rationale.
5. **Hospitalization or death**
 - If no return expected, complete discharge; if return expected, place on hold per payor rules.
6. **Unsafe environment / staff safety risk** (*last resort*)
 - After reasonable mitigation (family conference, MSW involvement, care plan adjustments), physician notified; safe alternative arranged.
7. **Nonadherence that makes care unsafe or ineffective** (*last resort*)
 - After documented education, problem-solving, and MD involvement, determine if alternate setting/provider is safer.

Important: QOC **does not discharge** simply because care is complex, costly, time-consuming, or because reimbursement is low/denied.

III. Discharge Protections & Patient Rights

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- Patients are informed of rights at admission (see **Patient Rights & Responsibilities Policy**).
- QOC ensures **no abandonment**: a **safe alternative** (another provider or level of care) is offered/arranged whenever possible.
- Language/communication needs are accommodated; teach-back used to confirm understanding of discharge instructions.

IV. Medicare Requirements (NOMNC & Appeals)

For Medicare/MA patients:

- Provide the **Notice of Medicare Non-Coverage (NOMNC)** within required timeframes prior to planned discharge.
- Inform patients of their **right to appeal** through the QIO; continue services as required pending decision.
- Document timing, delivery, and patient understanding of NOMNC and any appeals.
- Coordinate with the plan/QIO and physician during appeal; maintain safe care until determination.

V. Discharge Notification & Orders

- **Planned discharges:**
 - Notify patient/family **verbally and in writing**; document consent/understanding.
 - Notify and obtain **physician order** prior to discharge (unless patient refuses services).
 - Give **advance notice** (generally ≥ 48 hours) when feasible.
- **Urgent discharges (safety/behavioral risk):**
 - Notify physician **immediately**; document risks and mitigation; ensure safe transition where possible.

VI. Transfer to Another Agency/Level of Care

- With patient consent, QOC coordinates transfer to another HHA, SNF, IRF, LTACH, outpatient clinic, hospice, or community program.
- QOC provides a **warm handoff**: direct clinician-to-clinician communication whenever possible, and timely transmission of the discharge/transfer summary and relevant records.

VII. Discharge Summary



Complete within 48 hours of discharge (matches your prior policy). Summary includes:

- Reason for discharge and type (planned, transfer, refusal, hospitalization, death)
- Patient condition/status at discharge (clinical, functional, psychosocial)
- Services provided and **goals achieved/not achieved** with rationale
- **Medications** at discharge; outstanding orders/monitoring needs
- Education provided; caregiver competence/teach-back confirmed
- **Equipment/supplies** in home; vendor contacts
- Referrals made (e.g., outpatient PT, wound clinic, MSW, community resources)
- **Follow-up appointments** (PCP/specialist) and who scheduled them
- Physician notification and final orders
- NOMNC/appeal information (when applicable)
- Contact information for questions post-discharge

VIII. Continuity of Care & Post-Discharge Follow-up

- Provide written discharge instructions (plain language; patient's preferred language).
- Send discharge summary and key documents to the **physician/next provider** promptly.
- **Follow-up calls:**
 - **Day 3** to confirm safety, meds, wound/therapy plan, equipment in place.
 - **Day 7** to reassess status, barriers, and address problems—helps reduce readmissions.
- For high-risk patients (e.g., CHF, COPD, complex wounds), consider an extra check-in within **24–48 hours**.

IX. Documentation Standards

- Document all notifications, patient/caregiver education, physician communications, NOMNC/appeal steps, and handoffs.
- File the discharge summary and related artifacts in the **EHR within 48 hours**.
- Use standardized checklists to ensure completeness and consistency.

X. Roles & Responsibilities

- **Primary Clinician (RN or lead therapist):** coordinates discharge plan; completes summary; educates patient/caregiver.
- **Physician/Allowed Practitioner:** reviews progress; issues discharge/transfer orders; collaborates on plan.

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- **Therapists (PT/OT/ST):** update functional status, equipment needs, and outpatient plans.
- **Medical Social Worker:** addresses psychosocial barriers; links to community resources; assists with safe disposition.
- **Home Health Aide:** provides input on daily function/self-care; reinforces education.
- **Intake/Scheduling/Billing:** finalize logistics, benefits, and notify payor as needed.

XI. Quality & Compliance Integration

- Admission timeliness, unplanned discharges, appeals, readmissions within 30 days, and post-discharge call completion are tracked in **QAPI**.
- **Case reviews** are performed on discharges related to safety/nonadherence to ensure appropriate mitigation steps were taken and no abandonment occurred.
- Trends inform staff education, process improvement, and resource allocation.

XII. Policy Governance

- Reviewed at least **annually**; updated to maintain compliance with **CMS Conditions of Participation (42 CFR 484.50 & 484.58)**, **COMAR 10.24.16.08 A/B/G/I/K**, and **Joint Commission** standards.
- Staff receive training on any changes; compliance is monitored via chart audits and QAPI metrics.



APPEALS, DOCUMENTATION, QUALITY, GOVERNANCE

I. Patient Appeals & Grievances

Patients have the right to voice concerns without fear of retaliation.

QOC maintains a **formal grievance and appeal process** consistent with Medicare Conditions of Participation and QOC's **Patient Rights & Responsibilities Policy**.

Patients may appeal:

- Denial of admission
- Proposed discharge or reduction in services
- Quality concerns
- Staff behavior or communication
- Any aspect of their care

Appeal process:

1. Patient/family may submit verbally or in writing.
2. QOC leadership reviews within **5 business days**.
3. A written response is provided with findings and resolution.
4. Unresolved issues may be escalated to **external agencies** (e.g., MDH, MHCC, CMS, Joint Commission).

For Medicare beneficiaries:

- QOC will provide the **Notice of Medicare Non-Coverage (NOMNC)** before discharge.
- Patients have the right to a **fast appeal** through the **Quality Improvement Organization (QIO)**.
- QOC will comply with all QIO determinations and continue care as required during appeals.

II. Documentation Requirements

QOC maintains complete and accurate records for all admissions and discharges in accordance with CMS, COMAR, and Joint Commission requirements. Documentation includes:

- Referral and intake data
- Initial and comprehensive assessments
- Home safety and environmental evaluations
- Plan of Care (physician-signed and updated)
- Interdisciplinary notes and communications
- Discharge planning activities
- Physician notifications and orders
- NOMNC and appeal documentation (if applicable)
- Final discharge summary (completed within **48 hours**)
- Referrals and handoff documentation
- Patient education and follow-up contact

All documentation is securely maintained in the Electronic Health Record (EHR).

III. Quality Assurance & Performance Improvement (QAPI) Integration

QOC uses admission and discharge data to monitor and improve performance.
The following indicators are reviewed regularly:

Admission-related Metrics:

- Time from referral to admission (48-hour target / same-day options)
- Admission delays and root causes
- High-acuity and pediatric admissions

Discharge-related Metrics:

- Discharge reasons by category (goals met, patient refusal, transfer, safety)
- Unplanned discharges
- 30-day hospital readmission rates
- Discharge documentation timeliness (<48 hours)
- Post-discharge follow-up completion (Day 3 and Day 7)
- Medicare appeals and outcomes

Quality & Patient Experience:

- Patient/caregiver satisfaction
- Continuity of care outcomes

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- Identified barriers to care
- Staff competency and training needs
- Opportunities for improvement

Actions from QAPI may include:

- Staff education or re-training
- Process changes
- Policy updates
- Resource allocation
- Collaboration with referral partners

IV. Staff Training & Competencies

All staff involved in referral, admission, service delivery, and discharge are trained on:

- This Admission & Discharge Policy
- Patient Rights & Responsibilities
- CMS Conditions of Participation
- COMAR 10.24.16 standards
- Documentation requirements
- Communication protocols
- Cultural competence and health equity
- Pediatric and high-acuity care processes (as applicable)

Training is provided:

- During orientation
- Annually
- As needed based on QAPI findings or regulatory changes

Competency is validated through:

- Skills checklists
- Direct observation

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- Chart audits
- Performance reviews

V. Policy Review & Governance

This policy is reviewed **annually** by:

- Director of Nursing / Clinical Director
- Administrator / Executive Leadership
- QAPI Committee
- Compliance Officer (if applicable)

QUALITY ONE CARE HOME HEALTH, INC

~ We Care with Golden Hands ~



**NEW PATIENT
HANBOOK**



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Phone: +1 (301) 658-7141 / Email: info@qualityonecare.com

Web: <https://www.qualityonecare.com>

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WELCOME TO QUALITY ONE CARE

Dear Patient and Family Members,

Welcome, and thank you for choosing Quality One Care Home Health, Inc (QOC). We are honored to have you as a client and appreciate the opportunity to provide care within the comfort of your home. QOC is dedicated to offering a comprehensive range of home health services aimed at promoting, maintaining, and restoring health, while also minimizing the impact of illness and disability.

Our commitment is to deliver high-quality care through our compassionate and dedicated staff, which includes nurses, home health aides, and other professionals who empathize with your concerns during times of illness and the need for home care.

This booklet is designed to furnish you with essential information regarding your home care services. We encourage you to carefully review all the contents within this booklet. Should you have any concerns or questions about our services, please do not hesitate to reach out to any member of our management team. You can find their contact information, along with other important phone numbers, in this booklet and on your home care chart.

Wishing you a swift recovery!



Mohamed Matope, RN
Director

HOURS OF OPERATION

Hours of Operation:

Quality One Care Home Health Inc (QOC) office hours are Monday through Friday, from 9:00 am to 5:00 pm, except during company holidays.

For All Life-Threatening Emergencies:

In the event of a life-threatening emergency, please dial 911 immediately, then notify Quality One Care Home Health Inc. at 301-658-7141.

After Hours Coverage:

We offer 24-hour on-call service, seven days a week, ensuring you receive necessary home care services. In a medical emergency, proceed to the nearest hospital emergency room or dial Emergency Medical Services (911). Please refer to the On-Call Guidelines on Page 5 for further information.

Weather Conditions:

During seasons of inclement weather, such as snow, ice, or floods, we strive to maintain home care visits. However, the safety of our staff is paramount. If road conditions pose hazards, our staff will attempt to contact you by phone to inform you of any visit cancellations or schedule changes.

Emergency Preparedness Plan:

In cases of environmental or natural disasters (e.g., earthquake, blizzard, flood), or emergencies, we have an emergency plan in place to ensure continuity of patient services. Every effort will be made to meet your medical needs during such events.

All patients are assigned a priority level Code that is updated as needed. The code assignment determines the agency's response priority in case of a disaster or emergency. These codes are maintained in the agency's office, along with information that may be helpful to Emergency Management Services in case of an area disaster or emergency.

On-Call Guidelines:

A licensed nurse is always on call at our agency and is available after regular office hours. If you experience a change in your condition, please try to contact the office during regular office hours so that we can assess whether a visit is necessary and communicate with your physician if needed. However, we are available after regular office hours for urgent conditions only. Please note that we do not carry medications with us and cannot administer anything unless it has been ordered by your physician. Below is a list of some reasons for which you may need to contact our agency after regular hours:

- **Chest Pain:** Chest pain usually requires that you be seen by your physician either in the office or emergency room for diagnostic studies.
- **Fever:** Elevations in temperatures above 100°F should be called in, and instructions may be given over the telephone. A home visit may be necessary.
- **Respiratory Distress:** Severe respiratory distress usually requires evaluation by your physician. You may be instructed in ways to ease shortness of breath, proper use of respiratory aids, or oxygen if these are ordered by your physician.
- **Catheters:** Catheters are not an emergency unless you are unable to urinate. Usually, someone can wait 6-8 hours at night without a catheter if they are not taking in liquids. If the catheter does not drain or comes out and you are unable to urinate, you may need to call. You will be taught to either irrigate or remove the catheter if it becomes stopped up. If it is leaking or comes out, pad yourself well with absorbent cloths and call early in the morning so someone can be scheduled to visit.
- **GJ Tubes:** If the GJ-Tube dislodges (comes out) place lower size G-Tube to keep stoma open. Do not use it. Send the patient to the emergency room.

Calls or Injuries:

Notify the on-call nurse or call 911. Routine supplies or equipment cannot be delivered after regular hours. Any questions you may have concerning these guidelines can be answered by your nurse or by calling the office during regular office hours.

CUSTOMER SATISFACTION

Your satisfaction is of utmost importance to us. If there is anything unclear about our services, the care you receive, or if you feel you are not receiving the care you require, please do not hesitate to ask questions. Periodically, our agency conducts a Patient Satisfaction Survey to gather feedback. Your responses are invaluable in helping us enhance our services and ensure that we consistently meet your needs and expectations. If you have any concerns or suggestions, we encourage you to share them with us. Your input helps us continuously improve and provide the best possible care.

PLAN OF CARE, TREATMENTS & SERVICES

We actively engage you, your caregiver, or designated representative, along with key professionals and staff members, in developing your personalized plan of care, treatment, and services. This plan is crafted based on identified problems, needs, and goals, as well as physician orders for medications, care, treatment, and services. It considers timeframes, your environment, and your personal preferences whenever possible. The overarching goal of this plan is to enhance your ability to care for yourself effectively. Moreover, effective pain management is recognized as a crucial component of your treatment.

Moreover, effective pain management is recognized as a crucial component of your treatment. We are committed to ensuring that your pain is addressed and managed appropriately throughout your care journey.

The plan may encompass various interventions and goals tailored to meet your specific needs, including but not limited to:

- Nursing care
- Medication management
- Personal care assistance
- Discharge planning and coordination.

Each of these interventions and goals will be customized to address your individual requirements, enhance your well-being, and facilitate your recovery and overall health. Our team is dedicated to working collaboratively with you and your caregivers to ensure that the plan is comprehensive, effective, and aligned with your preferences and objectives.

The plan is subject to regular review and updates as necessary, to ensure it remains responsive to your evolving needs. We actively encourage your participation in this process and are committed to providing any pertinent medical information to support you effectively.

It's important to acknowledge that you have the right to refuse any medication or treatment procedure. However, in such instances, we may request a written statement releasing the agency from any liability arising from such actions. We will, however, urge you to engage in discussions with your physician for advice and guidance regarding your decision.

Furthermore, please promptly inform the agency if you choose to enroll in Medicaid/Medicare, a private Health Maintenance Organization (HMO), or Hospice. It's worth noting that Medicaid/Medicare coverage for the services we provide may be affected if you are enrolled in an HMO or Hospice. Therefore, timely notification ensures appropriate adjustments can be made to your care plan and billing arrangements.

If Medicaid/Medicare home health services are denied, you will not be held liable for charges unless you have received notification from QOC stating that we understand certain services are no longer covered by Medicaid/Medicare. It's important to note that Medicaid/Medicare does not cover part-time or full private daily nursing or aides at home, prescribed or over-the-counter medications, or home-maker services or meals delivered at home. We will communicate any changes in coverage or services provided by Medicaid/Medicare to ensure transparency and clarity regarding your financial responsibilities.

If you are receiving Medicaid/Medicare benefits, you may receive a Medicaid/Medicare Summary Notice (MSN) after we have submitted a final claim for services. The MSN will detail the services provided, charges billed to Medicaid/Medicare on your behalf, and the amount Medicaid/Medicare paid. It's important to note that the MSN is not a bill; rather, it serves as a summary of the services rendered and the associated Medicaid/Medicare payments.

Should any changes occur in this policy regarding services or charges, you or your responsible party will be promptly notified. If you have any questions or concerns regarding charges or insurance billing, please don't hesitate to contact our office. We're here to provide clarification and assistance whenever needed.

GUIDELINES FOR INSURANCE BENEFITS IN HOME CARE

Insurance pays 100% for home care services if the following criteria is met:

1. **Homebound Status:** You are considered homebound if, due to illness or injury, it requires considerable effort for you to leave home, and your absences are infrequent or of relatively short duration. Exceptions include attending religious services, receiving healthcare treatment, or attending unique and infrequent special events such as family reunions, funerals, or graduations.
2. **Eligible Insurance Beneficiary:** You are an eligible insurance beneficiary under the care of a doctor who has ordered treatment. This care must be deemed reasonable and medically necessary by your healthcare provider.

3. **Skilled Care Requirement:** You require skilled care that can only be provided by licensed health professionals. These professionals may include nurses, physical and occupational therapists, speech-language pathologists, and medical social workers. You may also be eligible for a home health aide.

4. **Intermittent Care Need:** You need care on an intermittent basis, meaning that professional staff will visit your home to provide assessments, treatment, and teaching as ordered by your doctor. Insurance does not typically cover extended periods of time for healthcare staff to remain with you at home. The duration of the visit is determined by the specific treatment ordered by your doctor.

It's essential to verify your insurance coverage and consult with your healthcare provider to ensure that the services you require meet the eligibility criteria outlined by your insurance plan.

Insurance will send you an Explanation of Benefits (EOB). An EOB is not a bill; rather, it serves to detail the charges for your home care services and the payment made by your insurance to Quality One Care Home Health.

It's important to note that Quality One Care Home Health may bill you for any copayment or deductible portion not covered by your insurance payment.

Recognizing that insurance information is subject to change, we kindly request that you promptly notify us if you acquire any other insurance coverage or opt for a managed care insurance plan. This ensures that our records remain accurate and up to date.

If you have any questions regarding your insurance or need to update your information, please don't hesitate to call us at +1 (301) 658-7141. We're here to assist you with any inquiries you may have.

SCOPE OF SERVICES

Skilled Nursing Care encompasses a range of specialized services, including:

- Colostomy Care
- Diabetic Management and Education
- Medication Management
- Medical Management
- Pain Management
- Post-Surgical Care
- Wound Care
- Clinical Monitoring and Case Management
- Patient Education and Support
- IV Therapy Administration and Teaching, including Central Venous Catheter Care and Management
- Nutritional Support, including Enteral Nutrition and Total Parenteral Nutrition (TPN)

These skilled nursing interventions are designed to address various healthcare needs and promote your overall well-being under the guidance of trained and licensed nursing professionals.

Physical Therapy Services are tailored to assist individuals dealing with acute nerve, orthopedic, or muscle disorders. Your therapist will develop a customized program that includes light exercise or stretching activities aimed at improving movement and mobility. This routine is designed to address your specific condition and help you regain functionality, reduce pain, and enhance your overall quality of life.

The benefits of therapy may include improvement in your strength, joint mobility, pain management, cardiopulmonary status, skin integrity, endurance, energy management, wound healing, adaptation to environment, equipment management, secretion elimination, safety awareness, and posture. Physical therapy may also increase your functional ability, muscle relaxation, motor control, balance, and coordination. Therapy may decrease or eliminate pain, minimize impairment, and remove necrotic tissue.

The risks associated with physical therapy may include muscle soreness, strain, or sprain; skin breakdown, redness, irritation, or burns; increase in pain; fatigue, edema, bleeding at the debridement site, fainting, increased tingling in your upper or lower extremities, shortness of breath, deterioration in your diagnosis, and if you have cancer, increased growth of cancer.

Occupational Therapy Services focus on assisting individuals in regaining fine motor coordination and enhancing activities of daily living (ADLs) such as dressing and feeding. These services are specifically tailored to address your unique needs and challenges, aiming to improve your independence and quality of life. Through targeted interventions and personalized strategies, occupational therapists work with you to enhance your ability to perform everyday tasks and achieve greater autonomy in daily living.

Speech Therapy Services aim to enhance communication skills for individuals experiencing impaired language and speech, cognitive function issues, or difficulties with chewing or swallowing. Through personalized interventions and exercises, speech therapists work with patients to address specific challenges and improve overall communication abilities. Whether it's enhancing language comprehension, articulation, cognitive abilities, or addressing swallowing difficulties, speech therapy is tailored to meet the unique needs of everyone, ultimately striving to improve their quality of life and functional independence.

Home Health Aide Services are recommended to support activities of daily living (ADLs) and assist individuals in regaining fine motor coordination and improving their ability to perform tasks such as dressing and feeding, among others. These services are designed to provide personalized assistance and support to individuals who may require help with various ADLs due to illness, injury, or other health conditions. Home health aides work closely with patients to promote independence and enhance their overall quality of life by helping with tasks essential for daily functioning.

KNOW YOUR RIGHTS



As our patient, you and your family or caregivers have the right to be actively involved in your care. We respect your autonomy and strive to ensure that your preferences and concerns are taken into consideration.

- 1. You have the right to be treated with consideration, respect, and dignity, and to receive appropriate and quality service in a timely manner without discrimination based on age, race, sex, handicap status, national origin, or sexual preference.** Both patients and caregivers are entitled to mutual respect and dignity. Our staff is strictly prohibited from accepting gifts or borrowing from you. This ensures a professional and ethical relationship between our staff and those under our care.

2. **You have the right to receive information in a manner that is understandable to you.** We are committed to providing clear and concise communication regarding your care, treatment, and services, ensuring that you have the information necessary to make informed decisions about your health and well-being. If you have any questions or concerns about the information provided, please don't hesitate to ask, and we will do our best to clarify and address them.
3. **You have the right to participate in the planning or changes in your plan of care, treatment, and services whenever possible and to the extent that you are competent to do so.** Additionally, **you have the right to be informed of any changes in the care, treatment, and services provided by the home health agency.** Your input and involvement are valuable in ensuring that your care plan aligns with your preferences, needs, and goals. We are committed to keeping you fully informed and involving you in decisions about your care.
4. **You have the right to be instructed in appropriate care techniques.** Our team provides you with the necessary knowledge and skills to manage your care effectively. Whether it involves wound care, medication management, mobility assistance, or any other aspect of your care, we will ensure that you receive clear and thorough instructions tailored to your specific needs. Our goal is to empower you with the knowledge and confidence to participate actively in your own care and promote your overall well-being.
5. **You have the right to make informed treatment decisions and retain the autonomy to refuse any portion of planned care, treatment, or services without relinquishing other portions of the treatment plan, except when there are medical contraindications to partial treatment.** We respect your right to actively participate in decisions about your health and well-being. Our team will provide you with comprehensive information about your treatment options, including the risks, benefits, and alternatives, to support you in making decisions that align with your preferences and values. Your choices will be respected, and we will work with you to ensure that your care plan reflects your individual needs and goals.
6. **You have the right to be educated about your pain management options, as well as the role your family can play in managing pain when appropriate.** Our team is committed to providing you with comprehensive information about the potential limitations and side effects of pain treatments, empowering you and your family to make informed decisions about your care. We will work closely with you to develop a personalized pain management plan that addresses your individual needs and preferences while minimizing any potential risks. Your comfort and

well-being are our top priorities, and we are here to support you every step of the way in managing your pain effectively.

- 7. You have the right to receive care without discrimination based on whether an advance directive has been executed.** Regardless of your decisions regarding advance directives, you will be treated with dignity, respect, and the same high standard of care. Our commitment to providing quality care is unwavering, and we will ensure that your wishes and preferences are honored to the best of our ability, in accordance with ethical and legal guidelines. You can trust that you will receive compassionate and equitable care from our team, regardless of your advance directive status.
- 8. You have the right to expect privacy and confidentiality regarding your written, verbal, and electronic information, including your clinical record, medical care program, and social and financial circumstances related to your care.** We are committed to maintaining the confidentiality of your personal and health information in accordance with applicable laws and regulations. Our Notice of Privacy Practices provides detailed information about your rights regarding privacy and confidentiality. Your trust is important to us, and we take all necessary measures to safeguard your information and ensure that it is only shared when appropriate and authorized.
- 9. You have the right to receive assistance in coping with the eventuality of death.** Our team is here to provide support and guidance to you and your loved ones during this difficult time. We understand that facing the end of life can be challenging, and we are committed to offering compassionate care and resources to help you navigate this journey with dignity and peace of mind. Whether it involves emotional support, spiritual guidance, or practical assistance with end-of-life planning, we are here to support you every step of the way. You are not alone, and we will do everything we can to ensure that you and your loved ones feel supported and cared for during this time of transition.
- 10. You have the right to receive reasonable continuity of service.** We provide consistent and reliable care to meet your ongoing needs. Our goal is to ensure that you receive the necessary support and assistance on a regular basis, maintaining continuity in your care plan to promote your health and well-being. We strive to minimize disruptions and ensure that you can rely on our team for the care and assistance you require, fostering trust and confidence in our services. If there are any changes or disruptions to your care, we will communicate with you promptly and

work to address any concerns to the best of our ability. Your continuity of care is important to us, and we are committed to providing the support you need to live your best life.

- 11. You have the right to receive, upon request, information concerning the identity and responsibilities of the individuals responsible for your health care.** We are committed to transparency and will provide you with information about the members of our team who are involved in your care, including their roles and responsibilities. If you have any questions or concerns about your care providers, please don't hesitate to ask, and we will ensure that you have the information you need to feel informed and confident in the care you receive. Your comfort and peace of mind are important to us, and we are here to support you every step of the way.
- 12. You have the right to have your property, personal privacy, and security treated with respect during home care visits.** We are committed to ensuring that your home environment is respected and that your privacy and security are always maintained. You have the right to unlimited contact with visitors or others, and we will facilitate private communication with these individuals as needed. Your home is your sanctuary, and we will take all necessary precautions to ensure that you feel comfortable and secure while receiving care. If you have any concerns about privacy or security during home care visits, please let us know, and we will address them promptly to ensure your peace of mind.
- 13. You have the right to be informed of the various health care disciplines providing care or services and the frequency of proposed visits.** We are committed to transparency and will provide you with clear information about the different healthcare professionals involved in your care, as well as their roles and responsibilities. Additionally, we will communicate the frequency of proposed visits, ensuring that you are informed about the schedule and timing of appointments.

Our goal is to keep you fully informed and involved in your care plan, empowering you to make informed decisions about your health and well-being. If you have any questions or concerns about the disciplines providing care or the frequency of visits, please don't hesitate to ask, and we will be happy to provide clarification and address any concerns you may have.

14. You have the right to be fully informed, verbally and in writing, of the following:

- All items and services furnished by the home health agency for which payment may be made under Medicaid/Medicare.
- The coverage available for items and services under Medicare, Medicaid, and any other federally funded program for which the home health agency is responsible.
- Any charges for items and services not covered under Medicare, Medicaid, and/or private insurance, including the approximate maximum dollar amount that the individual may have to pay for items and services furnished by the home health agency.
- Any changes in the charges for items and services for which the individual may be liable within thirty (30) calendar days of the changes, to the extent that the home health agency is aware.

We are committed to providing clear and transparent information about your coverage and any associated costs, ensuring that you have a complete understanding of your financial responsibilities. If you have any questions or concerns about billing or charges, please do not hesitate to reach out, and we will be happy to provide clarification and assistance. Your peace of mind is important to us, and we are here to support you every step of the way.

15. You have the right to receive, upon request, a fully itemized billing statement, including the date of service and unit charge for each item or service provided.

We are committed to transparency and accountability in our billing practices, and we will provide you with detailed information about the charges associated with your care. If you have any questions or concerns about your billing statement, please don't hesitate to reach out, and we will be happy to provide clarification and assistance. Your satisfaction and understanding are important to us, and we are here to ensure that you have the information you need regarding your financial responsibilities.

16. You have the right to receive, upon request, the Agency's policy on uncompensated care.

We are committed to providing transparency regarding our policies and procedures, including those related to uncompensated care. If you would like to learn more about our approach to uncompensated care or have any questions about our policies, please feel free to reach out, and we will be happy to provide you with the information you need.

Your understanding and peace of mind are important to us, and we are here to support you every step of the way.

17. You have the right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation. We are committed to providing a safe and supportive environment for all individuals under our care, and we strictly prohibit any form of abuse or neglect. Our team is trained to recognize and prevent instances of abuse or exploitation, and we take all necessary measures to ensure the safety and well-being of our clients.

If you ever feel that your rights are being violated or that you are experiencing any form of mistreatment, please don't hesitate to reach out to us immediately. Your safety and dignity are our top priorities, and we are here to support you and address any concerns you may have.

18. You have the right to file a written complaint with the agency, with the assurance that said complaint will be duly investigated by our agency and that a copy of a written summary report will be offered to you. We take all complaints seriously and are committed to addressing any concerns you may have in a prompt and thorough manner. You have the right to voice your grievances without fear of coercion, discrimination, or reprisal, and we will ensure that your care, treatment, or services are not unreasonably interrupted for voicing grievances. Your feedback is important to us, and we are dedicated to continuously improving our services based on your input. If you have any concerns or complaints, please don't hesitate to reach out, and we will do everything we can to address them and ensure your satisfaction.

19. You have the right to voice a complaint, including concerns about advance directives implementation, or to ask questions about home health care without fear of discrimination or reprisal, please call any of our clinical supervisors at (301) 658-7141 between 9:00 am and 5:00 pm, Monday through Friday. Your feedback is valuable to us, and we are committed to addressing any concerns you may have promptly and effectively.

If you feel that Quality One Care was not able to resolve your complaint satisfactorily, you can contact the Department of Health and Mental Hygiene (DHMH) as a last resort. Your right to voice complaints and seek resolution is important to us, and we encourage you to reach out if you have any concerns about your care or services. We are here to support you and ensure that your needs are met to the best of our ability.

20. You have the right to have your cultural, psychosocial, spiritual, personal values, beliefs, and preferences respected. At Quality One Care, we are committed to providing culturally sensitive and inclusive care that honors your individuality and uniqueness. We do not discriminate based on social status, political belief, sexual preference, race, color, religion, national origin, age, sex, or handicap status. Your dignity and autonomy are paramount, and we strive to create an environment where you feel valued, understood, and respected. If you have specific cultural or personal preferences that you would like us to consider in your care, please let us know, and we will do our best to accommodate your needs. Your well-being is our priority, and we are here to support you in living a fulfilling and meaningful life according to your own values and beliefs.

21. You have the right to have your family involved in decision-making as appropriate concerning your care, treatment, and services, when approved by you or your surrogate decision-maker and when allowed by law. At Quality One Care, we recognize the importance of family involvement in the healthcare decision-making process. Your family members can provide valuable support and insight into your preferences and needs, and we welcome their input when it comes to planning your care.

However, we also respect your autonomy and recognize that you may have specific wishes regarding who is involved in your care decisions. If you prefer to have family members involved, we will work closely with you to ensure that their participation is aligned with your preferences and best interests. Additionally, we will always adhere to relevant legal requirements regarding decision-making and confidentiality.

Your comfort and well-being are our top priorities, and we are committed to working collaboratively with you and your family to develop a care plan that meets your unique needs and preferences. If you have any questions or concerns about family involvement in your care, please don't hesitate to discuss them with us. We are here to support you every step of the way.

22. You have the right to access, request changes to, and receive an account of disclosures regarding your own health information as permitted by law. At Quality One Care, we are committed to protecting your privacy and confidentiality, and we adhere to all applicable laws and regulations regarding the handling of your health information.

If you would like to access your health information, request changes to it, or receive an account of disclosures, please contact us, and we will provide you with the necessary forms and guidance to facilitate these requests. We understand the importance of maintaining control over your health information and will work closely with you to ensure that your rights are respected and upheld.

Your privacy and confidentiality are of the utmost importance to us, and we provide you with the information and support you need to make informed decisions about your care. If you have any questions or concerns about accessing or managing your health information, please don't hesitate to reach out to us. We are here to assist you every step of the way.

These rights are intended to empower you and ensure that your healthcare experience is centered around your needs, preferences, and goals.

KNOW YOUR RESPONSIBILITIES

As our patient, you have the responsibility to:

- Remain under a physician's care while receiving the Agency services and inform the Agency whenever you change physicians.
- Provide the Agency with a complete and accurate health history to plan and carry out care.
- Inform Agency staff about any changes in your health status, condition, treatment, medication, including re-hospitalizations, doctor's appointments, as well as the need for home care visit schedule changes.
- Provide the Agency with all requested insurance and financial information/records.
- Sign or have your legal representative sign the required consents and releases for insurance billing.
- Participate in your plan of care by following the mutually agreed-upon home care treatment plan so that you can fully benefit from home care services.
- Inform the Agency if you do not understand or are unable to take part in your own care.
- Arrange for a family member or friend who is willing, available, and capable of providing your care if you are unable to care for yourself.
- Recognize the responsibility of the Agency to reduce services as your condition improves and discontinue services once the goals of care have been met.
- Be available to the Agency staff for home visits at reasonable times.
- Notify the Agency if you are going to be unavailable for a visit.
- Treat the Agency personnel with respect and dignity without discrimination as to color, religion, sex, or national or ethnic origin.
- Notify the Agency of any problems or dissatisfaction with your care.
- Accept the consequences for any refusal of treatment or choice of noncompliance.
- Provide the Agency personnel with a safe home environment in which your care can be provided.
- Inform the Agency if you are no longer homebound and, therefore, no longer entitled to home care services.

By fulfilling these responsibilities, you contribute to the effectiveness and success of your care plan and help ensure the best possible outcomes for your health and well-being. If you have any questions or concerns about your responsibilities as a patient, please don't hesitate to discuss them with us. We are here to support you in your journey to better health.

While the Agency is providing you with home health services, it is important that you focus on your care. Therefore, we want to ensure that you understand your financial responsibility and address any questions you may have before the start of care. You will then be required to sign a Service Agreement/Patient Responsibility form. This gives the Agency the authority to complete the necessary paperwork and bill you or your health insurer directly for your care. We will bill you or your insurer weekly or at an agreed-upon interval, and payments are due upon receipt. Other accrediting bodies, licensing, or certifying agencies may also review the Service Agreement.

During the admission visit, the admitting clinician will ask you to provide your insurance information. Even if you have already provided this information, we will need to see it again to ensure that the information we have is correct. Information you may be asked to provide includes, but is not limited to, the following:

- Complete insurance identification numbers.
- Names and addresses of all insurance policies you and your spouse have.
- Names of policyholders.

Most health insurance companies or third-party payers, such as Medicare, Medicaid, Blue Cross, and managed care companies, offer home health coverage. The amount of coverage varies, but it can be as high as 80% to 100%, leaving you with a small to no co-payment. Most of these payers cover most of the services we offer, such as nursing, therapy, and medical social work.

In cases where the services you require are not covered by your insurance, you have the option of paying for these services if you decide to accept the uncovered services. Most third-party payers allow for direct billing by the Agency. In the cases of those who do not, you will be billed directly by the Agency and responsible for the charges. Check with your insurance company to determine if they will send payment to the Agency directly or reimburse you for what you pay to the Agency directly.

If you anticipate having difficulty paying for services for which you are responsible, let us know. The agency will work with you to develop a payment plan based on your income and expenses. If you have no resources, we can advise you on how to apply for medical assistance. If you are ineligible for medical assistance, please ask if the Agency has any charitable funds available for which you may apply. If you have any questions about the agency bill, please give us a call. We will be happy to assist you.

YOUR DOCTOR'S RESPONSIBILITIES

Your doctor's signature is legally required on the treatment plan for home care services to be provided. The treatment plan, which includes specific medical orders, is sent to your doctor to sign, and return to the Agency.

SCHEDULING AND CANCELING VISITS

Your Scheduled Visits: Your primary nurse will discuss with you the number and frequency of visits you will need as part of your home care plan. The names of your home care staff and the telephone number for the home care office will be provided for your convenience.

Canceling Visits: In today's healthcare environment, we must be very conscious of using our staff's time wisely. We understand that sometimes you may need to cancel a visit, especially when you have a doctor's appointment. When this is necessary, we require that you call the Agency to inform the supervisor or scheduler about the schedule change. Please provide your name, address, and the name of the nurse, therapist, or home health aide, who needs to know about the cancellation. This will prevent staff from coming to your home to deliver service when you are not there. We are here to work with you and your doctor to help you meet the goals of your care. This becomes challenging if there are frequent cancellations. Please be aware that after three (3) cancellations for reasons other than a doctor's appointment, or if we visit you three (3) times and you are not home, we may discontinue services after notifying you and your doctor. This notification will be provided in writing, along with the names of three other agencies that you may contact to receive home care services.

MAKING DECISIONS ABOUT YOUR MEDICAL CARE

The law recognizes three ways of making healthcare decisions for the future, including decisions about treatments needed to sustain life. These three ways are an advance directive, a power of attorney for healthcare, and a documented discussion with your physician.

- **Advance Directive (also known as Living Will or Healthcare Instructions):** This is a written document that outlines a person's preferences for medical treatment if they become unable to communicate their wishes due to illness or incapacity.
- **Durable Power of Attorney for Healthcare (also known as Appointment of Healthcare Agent):** This is a legal document that designates a healthcare agent to make medical decisions on behalf of a person if they become incapacitated and are unable to make decisions for themselves.
- **Documented Discussion with Physician:** This refers to a recorded conversation or note in your medical record where you discuss and make decisions regarding the use of life-sustaining treatment during a consultation with your physician. This documentation is legally valid in the state of Maryland.

We encourage you to exercise your legal rights to healthcare decision-making. We will honor your wishes and offer support during the time that we are providing you with care.

- Social workers can help you fully understand Advance Directives and assist you in clarifying your healthcare wishes and decisions.
- If you already have an Advance Directive, we strongly suggest that a copy be kept in this handbook for accurate reference by all our clinicians in case of an emergency.

You can obtain the Advance Directive and Power of Attorney forms provided by Maryland from the following sources:

- Maryland Department of Health
- Local hospitals or healthcare facilities
- Legal services or attorney offices specializing in healthcare directives.
- Online resources such as the Maryland state government website or legal document websites

Additionally, you may contact your healthcare provider or social worker for guidance on obtaining these forms.

OBTAINING A COPY OF YOUR MEDICAL RECORD

Agency employees are responsible for maintaining the confidentiality of your medical records. You have the right to request the release of information from your medical records.

Access to individual patient's medical and financial information shall be limited to the patient, their designated representatives, legal guardian, or legal representative, except as required by law or third-party payment contracts, accrediting bodies, licensing, or certifying agencies.

The Following Guidelines May Be Used to Request the Release of Your Medical Records:

Call the Agency and request a patient authorization to release information form. Forward the form, signed by the patient (or designee with power of attorney), or a court subpoena to the Administrator, supervisor, or designee, or write a letter to the Administrator, supervisor, or designee. Include the following information:

- Your full name and date of birth
- Date of treatment
- Name and address of the person or facility to which disclosure is to be provided.
- The specific kind and amount of information to be disclosed, such as laboratory results or clinical notes on your chart.
- The purpose of the request, for example, "continuing care" or "insurance"
- Your signature and date

COMPLAINTS AND GRIEVANCE PROCEDURES

The information provided below outlines the grievance process for you or your representative to follow if you wish to file a grievance.

- The client or client representative shall be provided with a copy of the complaint process at the time of admission to the agency. This process specifies that complaints are to be filed with the agency's administrator without fear of retaliation or disruption of services.
- The agency shall provide each client or client's representative with the name, mailing address, and telephone numbers of the following:

**Quality One Care Home Health Agency
(QOC)**

9221 Colesville Road,
Silver Spring, MD 20910
Phone: 301-658-7141

The Office of Health Care Quality (OHCQ)

7120 Samuel Morse Drive, 2nd Floor.
Columbia, MD 21046
Phone: 410-402-8094
Hotline Number: 800-492-6005

Maryland Department of Health

201 Preston Street
Baltimore, MD 21201
Phone: 410-767-6500
Toll-free: 1-877-463-3464

Office of Quality and Patient Safety

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace,
Illinois, 60181

- Complaints and grievances can be made verbally or in writing.

- QOC's Administrator will log the complaint or grievance in the designated logbook and immediately acknowledge the receipt of the complaint either in writing or verbally, reassuring the complainant that action is being taken to investigate the matter.
- The Administrator will investigate the complaint or grievance.
- The administrator will develop a written report that recounts all pertinent issues involved in the complaint or grievance investigation, as well as the recommendations, within ten (10) days of receipt of the complaint or grievance.
- A written decision or remedy will be sent to the person who lodged the complaint, and a copy of the decision will be filed and recorded.
- If a patient or family member indicates dissatisfaction with the agency's response, either verbally or in writing after resolution is made, they shall be informed that they have the right to initiate an appeal in writing within 10 business days of the response or forward the complaint to the Department of Health.

HOME INFUSION SAFETY GUIDELINES

Ambulatory Pump or IV Pole Pump:

The electrical safety requirements for ambulatory pumps or IV pole pumps are crucial to ensure the safe and effective administration of medications or fluids. Here are some key points regarding electrical safety:

1. Continuous Power Supply:

- a. The pump should be always plugged in to maintain the battery charge. This ensures that the pump remains operational and can deliver medications or fluids consistently.
- b. The battery charge should only be utilized when the length of the power cord is inadequate or during a power failure. Relying on battery power should be minimized to ensure uninterrupted therapy whenever possible.

2. Avoiding Water Exposure:

- a. Patients should never take a bath or shower while using the pump. Water exposure can damage the pump and pose electrical hazards, leading to malfunctions or shocks.
- b. It's essential to keep the pump away from sources of water and moisture to prevent damage and ensure patient safety.

3. Preventing Spills:

- a. Patients should avoid spilling liquids, including solutions, on the pump. Liquid spills can cause electrical shorts or damage components, compromising the pump's functionality and safety.
- b. Care should be taken during handling and administration to prevent accidental spills near the pump.

4. Proper Outlet Usage:

- a. If a grounded electrical outlet is not available, a three-prong adapter must be used to ensure proper grounding. Grounding helps dissipate electrical charges safely and reduces the risk of electrical shocks or fires.

5. Proper Voltage and Amperage:

- a. Ensure that the electrical outlet provides the correct voltage and amperage for the pump. Using an outlet with insufficient voltage or amperage may result in the pump not functioning correctly or overheating.

6. Accessibility:

- a. Place the pump near an electrical outlet that is easily accessible. Avoid using extension cords or power strips unless necessary, as they can increase the risk of electrical hazards if not used properly.

7. Avoid Overloading Circuits:

- a. Do not overload electrical circuits by plugging in too many devices simultaneously. Overloading circuits can cause overheating and electrical fires. If other devices are connected to the same circuit, ensure that the total power draw does not exceed the circuit's capacity.

8. Regular Inspection:

- a. Periodically inspect the electrical outlet and plug for any signs of damage or wear. Cracked outlets, frayed cords, or loose connections should be addressed immediately to prevent electrical hazards.

9. Prohibition of Extension Cords:

- a. Extension cords should not be used with ambulatory pumps or IV pole pumps. Extension cords can pose tripping hazards and increase the risk of electrical hazards if not used properly. Always use a nearby electrical outlet that is easily accessible.

10. Familiarity with Alarm System:

- a. Be familiar with the pump's alarm system and understand what each alarm signifies. This ensures that you can respond appropriately in case of an alarm activation, which may indicate issues such as occlusion, low battery, or pump malfunction.

11. Proper Storage:

- a. When not in use, ambulatory pumps should be stored in the pouch provided to prevent tugging or damage to your catheter or the pump itself. Proper storage helps maintain the integrity of the equipment and reduces the risk of accidental damage.

Adhering to these electrical safety requirements helps mitigate the risks associated with using ambulatory pumps or IV pole pumps, promoting patient safety and treatment efficacy. Regular maintenance and inspection of the equipment are also essential to identify and address any potential electrical hazards promptly. It's crucial to be prepared for various emergency situations when using infusion therapy at home. Here are some safety precautions and guidelines to follow:

In Case of Fire:

- Immediately detach yourself from the IV pole or pump.
- Ensure that your ventral venous catheter is clamped.
- Leave the area and call for help.

Environmental Safety Precautions:

- Avoid using stairs while the pump or pole is in use.
- Remove any loose rugs or objects that could cause you to fall.
- Administer medication in an area with bathroom accessibility if possible.
- Secure excess tubing to avoid tangling.

For Any Infusion Therapy:

- Wear disposable gloves when exposure to blood or body fluids is possible.
- Dispose of all needles and contaminated syringes in the provided receptacle without recapping them.
- Seal the receptacle securely when it is two-thirds full and call the pharmacy or your home health agency for disposal instructions.

For Chemotherapy:

- Wear disposable gloves when handling liquid chemotherapy.
- Use a spill kit if there is a spill.
- Dispose of contaminated needles, syringes, and supplies in closed, leak-proof, puncture-proof containers without overfilling them.
- Place all other contaminated materials in provided chemotherapy bags and seal them.

For Narcotic Infusion:

- Safeguard all medication cassettes containing narcotics due to their potency and danger.
- Dispose of remaining contents of old medication cassettes into a toilet following a change.

For Natural and Unforeseen Disasters:

- Contact your home infusion company or healthcare provider for instructions if phone service is available.
- Proceed to the nearest emergency room if phone service is not available.
- Determine the closest hospital and alternative routes in case of emergency.
- Coordinate with family and friends regarding transportation to the nearest emergency room if necessary.
- Inform local authorities of your medical needs in case of a disaster.
- Obtain the phone number of the National Guard in your area.

By following these guidelines and safety precautions, you can ensure your well-being and effectively manage infusion therapy at home, even during emergencies or unforeseen events.

INFECTION CONTROL

It's crucial for both patients and caregivers to grasp infection prevention and control measures. This is essential in thwarting the transmission of severe illnesses like AIDS, hepatitis, tuberculosis, and infections in open wounds. Despite the omnipresence of germs and viruses, effective strategies can be employed to manage them.

Hand Washing & Hygiene:

- Wash your hands before eating, cooking, or handling wounds, bandages, or IV supplies.
- Also wash after using the bathroom, changing soiled bedding, or clothing, or handling bodily fluids.
- Use plenty of soap and warm water, rubbing your hands together for at least 30 seconds, especially before and after handling food, after using the bathroom, and after coughing or sneezing.
- Be sure to wash between your fingers.
- Dry your hands with paper towels or a clean towel.
- Our staff will use additional precautions when handling certain types of care involving bodily fluids, such as gloves, masks, goggles, gowns, or aprons.
- Use hand sanitizer with at least 60% alcohol if soap and water are not available.

Disposal of Hazardous Materials:

- Before disposing of soiled bandages, gloves, or other disposable items in public trash areas, wet them with a disinfectant solution like bleach.
- Then, place these items in two plastic bags and tightly seal them with tape or a tie.
- After handling waste, wash your hands thoroughly.

Sharp Objects Disposable Guidelines:

All needles, lancets, syringes, and other sharp objects should be placed in a rigid, leak-proof, puncture-resistant container with a tight-fitting lid. Suitable containers include detergent bottles, 2-liter pop bottles, plastic juice containers, coffee cans, or a purchased "sharps" container.

Avoid using glass containers, as they may break, or plastic milk jugs, as the plastic is too thin.

Remember to:

- Label all sides of the container with the word "sharps" in big letters.
- Keep all containers out of the reach of children.
- Do not use a container intended for recycling.

When the container is $\frac{3}{4}$ full, screw on the lid tightly and reinforce it with heavy-duty tape.

Return the securely closed container to your local pharmacy, doctor's office, hospital, clinics, outpatient laboratory, or hand it to your home care nurse for disposal.

Needles and Syringes:

- Needle and syringes must be disposed of in a hard, puncture-proof container with a tight lid. Your nurse will demonstrate proper disposal procedures and provide additional information.

Storage of Supplies:

- Store all patient care supplies in a clean, dry place. Avoid placing these items on the floor.
- Keep storage and disposal areas inaccessible to children and pets.
- Medications requiring refrigeration must be stored at the appropriate temperature in the refrigerator.

Soiled Linens:

- Sheets, towels, washcloths, pajamas, or other clothing soiled with blood, urine, or feces should be washed separately in hot, soapy water with half a cup of bleach added to the washing machine or wash tub.

Wound Care:

- Keep wounds clean and covered with sterile bandages to prevent bacteria from entering.
- Change dressings as instructed by healthcare providers.
- Follow proper techniques for wound cleaning and dressing changes.

Environmental Cleaning:

- Regularly clean and disinfect frequently touched surfaces such as doorknobs, light switches, and countertops.
- Use EPA-approved disinfectants and follow instructions for proper use.
- Launder linens, towels, and clothing regularly in hot water.

Food Safety:

- Wash fruits and vegetables thoroughly before eating.
- Cook foods to the appropriate temperatures to kill harmful bacteria.
- Store perishable foods in the refrigerator promptly.

Personal Protective Equipment (PPE):

- Wear gloves, masks, and PPE as instructed when providing care to individuals with infections.
- Dispose of PPE properly after use and wash hands immediately.

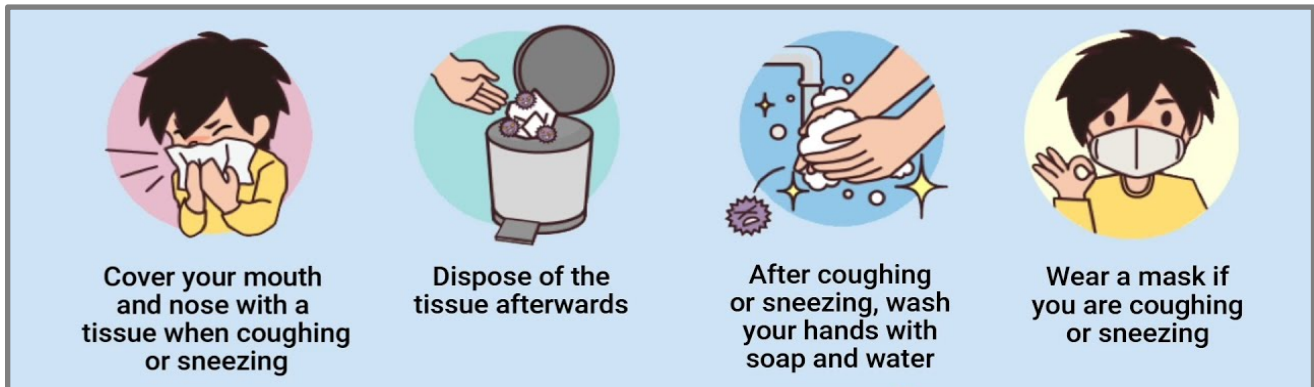
Vaccinations:

- Stay up to date on vaccinations, including flu shots and other recommended vaccines.
- Encourage household members and caregivers to receive vaccinations as appropriate.

Educate and Communicate:

- Educate patients, caregivers, and household members about infection prevention strategies.
- Communicate openly with healthcare providers about any signs or symptoms of infection.

Respiratory Hygiene/Cough Etiquette:



All individuals exhibiting signs and symptoms of a respiratory infection are advised to implement the following measures to contain respiratory secretions.

- Cover your mouth and nose with a tissue or your elbow when coughing or sneezing.
- Dispose of used tissues promptly in a waste receptacle.
- Wash your hands thoroughly with soap and water after coughing, sneezing, or disposing of tissues.
- Avoid close contact with individuals who are coughing or sneezing.
- If you don't have a tissue, cough, or sneeze into your elbow rather than your hands to prevent the spread of respiratory droplets.

Precautions to Prevent Infection:

- In some cases, certain bacteria can develop resistance to multiple antibiotics, leading to infections that are difficult to treat. To minimize the risk of spreading infection at home, caregivers should follow these precautions:
- Wash hands thoroughly with soap and water for at least 20 seconds after physical contact with an infected or colonized individual, before leaving the home.
- Handwashing is the most effective measure for controlling the spread of infection.
- Use towels for drying hands only once; consider using disposable paper towels.
- Wear disposable gloves if there is expected contact with body fluids & wash hands after removing gloves.
- Change and launder linens if they become soiled and do so at least once a week.
- Routinely clean the patient's environment, especially if it becomes soiled with body fluids.
- Double-bag soiled dressings and dispose of them in the trash.
- Launder clothes that come into contact with wound drainage.
- Avoid sharing personal hygiene items and eating utensils.

By following these guidelines and incorporating infection prevention practices into daily routines, individuals can minimize the risk of infections and promote better health outcomes.

HOME SAFETY GUIDELINES

Ensuring patient safety is paramount, especially considering that home accidents are a leading cause of injury and mortality, particularly among individuals aged 60 and above.

With age, agility diminishes, and bones become more prone to fractures. Consequently, even a minor fall can lead to severe injury or disability.

The Keys to Safe and Sensible Home Care Include:

1. Being aware of your home surroundings.
2. Making necessary changes to eliminate the risk of accidents.
3. Creating an emergency plan.
4. Ensuring that only authorized healthcare personnel with proof of employment at Quality One Care Home Health, Inc. (such as a name tag or ID card) are allowed into your home.

Electrical Safety:

- Ensure that electrical appliances and cords are clean, in good condition, and not exposed to liquids.
- Check that electrical equipment bears the Underwriters Labs (UL) label.
- Make sure there are an adequate number of outlets in each room without the use of "octopus" outlets.
- Verify that electrical outlets are grounded.
- Ensure adequate lighting throughout the house, especially in stove and sink areas.
- Keep curtains away from stove and other open flame areas.
- Install an exhaust hood with filters in the kitchen and ensure the exhaust system discharges directly outside.
- Maintain clean and uncluttered counter space and avoid storing heavy items above easy reach.
- Turn pan handles away from burners and keep hot pan holders near the stove.

- Operate microwave oven only when food is inside.
- Avoid cooking on high heat with oils and fat.
- Do not wear clothing with loose sleeves while cooking.
- Use refrigeration and proper storage to avoid food poisoning, keeping perishable foods refrigerated and periodically checking for freshness.
- Turn off kitchen appliances when not in use.

Disposable Items and Equipment:

- Disposable items include paper cups, tissues, dressings, soiled bandages, plastic equipment, urinary/suction catheters, disposable diapers, Chux, plastic tubing, and medical gloves.
- Store medical supplies in a clean and dry area.
- Dispose of used items in waterproof (plastic) bags.
- Fasten the bags securely and dispose of them in the trash.

Medical Equipment/Oxygen Safety:

- Follow manufacturer's instructions for proper use and maintenance of specialized medical equipment, keeping them nearby for reference.
- Perform routine and preventive maintenance as per manufacturer's instructions.
- Keep contact information for equipment service readily available in case of problems or failure.
- Ensure backup equipment is available when necessary.
- Provide adequate electrical power for medical equipment like ventilators and oxygen concentrators.
- Regularly check equipment batteries by a qualified service person.
- Install bedside rails properly and use only when necessary; do not use them as substitutes for physical restraints.
- Ensure mattresses fit the bed to prevent patients from getting trapped between the mattress and rails.
- Use protective barriers with bedside rails to reduce gaps where patients could be trapped.

- Keep all oxygen equipment away from open flames and ensure there is no smoking around oxygen.
- Prevent oxygen from freezing or overheating.
- If using electrically powered equipment like oxygen or ventilators, ensure registration with the local utility company.

Fire Safety Precautions:

- Ensure all family members and caregivers are familiar with emergency 911 procedures.
- Notify the fire department if a disabled person is present in the home.
- Prohibit smoking in bed or when oxygen equipment is in use.
- Regularly check and clean the heating system by qualified maintenance personnel.
- Maintain and use space heaters according to manufacturer's specifications.
- Ensure there are exits from all areas of the house and know fire escape routes for easy exit plans.
- Familiarize yourself with exit stair locations if living in an apartment building.
- Keep hallways clean and clear.
- Do not use elevators during a fire emergency.
- Prepare a fire drill/safety plan and practice escape routes from each room in the home.
- Display the fire department number prominently for easy access.
- Check fire extinguishers frequently for stability.
- Install smoke detectors in hallways and near sleeping areas.
- Regularly check and replace smoke alarm batteries when changing clocks for daylight savings time.
- In case your fire escape route is blocked, remain calm, close the door, seal cracks to prevent smoke entry, and signal for help at the window.

Bedbound Patient:

In the event of a fire, if a bedbound patient needs to be evacuated to a safe area, they can be placed on a sturdy blanket and carefully pulled or dragged out of the home. However, prioritize life safety above all else. If the fire is small and contained, you may consider using a fire extinguisher until the fire department arrives.

To Prevent Falls, Ensure the Following Safety Measures Are in Place:

- Maintain well-lit stairways and hallways.
- Use night-lights in bathrooms, halls, and passageways.
- Keep a flashlight or lamp within easy reach of the bed.
- Remove throw rugs or use ones with nonskid backing.
- Arrange electrical and telephone cords along walls and away from traffic areas.
- Use step stools with high handrails if necessary.
- Install secure handrails on stairs.
- Place grab bars near the shower, tub, or toilet.
- Attach shower stools or non-skid strips to the bottom of the tub.
- Consider using elevated toilet seats or stools.
- Clean up spills immediately.
- Keep outside walks clear of snow and ice.
- Be aware of medications that may cause dizziness.
- Limit alcoholic beverages.
- Rise slowly from seated or lying positions.
- Use a cane for extra stability if needed.
- Ensure steps are in good condition and free from objects.
- Use non-skid strips on steps or securely fastened carpeting.
- Install light switches at the top and bottom of stairways and in long halls.
- Ensure doors do not swing out over stairs or steps.
- Provide adequate headroom clearance in stairways.

To Ensure Bathroom Safety, Implement the Following Precautions:

- Use a non-skid mat or strips in the standing area of the bathtub or shower.
- Ensure bathtub or shower doors are made of safety glass or plastic.
- Install grab bars on the walls near the bathtub or toilet.
- Avoid using towel bars or soap dishes in the shower as grab bars.
- Keep electrical appliances away from the bathtub or shower area.
- Set the water heater thermostat below 120°F to prevent scalding accidents.
- Use night lights to illuminate the path to the bathroom at night.

To Manage Hazardous Items and Poisons Safely, Adhere to These Guidelines:

- Store hazardous items only in their original containers, exercising caution.
- Familiarize yourself with how to contact your local poison control team.
- Refrain from mixing products containing chlorine or bleach with other chemicals.
- Exercise caution with insecticides, purchasing only what is immediately needed and disposing of excess properly.
- Keep hazardous items, cleaners, and chemicals out of reach of children and individuals who may be confused or impaired.
- Dispose of household trash in a covered waste receptacle located outside the home.

To Ensure Medication Safety, Follow These Guidelines:

- Request snap caps from your pharmacist if child-proof caps are too challenging to open but keep them out of children's reach.
- Take your medication exactly as labeled or as instructed by your doctor.
- Understand the directions clearly; if unsure, consult your doctor, pharmacist, or nurse.
- Do not share prescribed medication with friends or family members; it is tailored specifically for you.
- Do not discontinue prescribed medication or restart an old prescription without informing your doctor.
- Maintain a list of all medications you are taking, noting dosage and timing, and bring this list along with your medication bottles to doctor's visits.
- Keep medication information sheets provided by the pharmacy.
- Discuss any side effects that you experience with your doctor or nurse.
- Inform your doctor about all medications you are taking, including nonprescription drugs, for guidance on safe and proper use.
- Check medication labels for expiration dates.
- Inspect your medicines for stability, looking for signs of discoloration, residue, or dampness.
- Always securely replace the lids of your medication bottles.
- Store medications according to the instructions provided by the pharmacy or package insert.

CREATE A HOME EMERGENCY KIT

Water:

- Store bottled water, one gallon per person per day, for drinking and sanitation.
- Keep water in a cool, dark place and replace every six months.

Food:

- Have a supply of nonperishable food for 3-5 days per person.
- Include ready-to-eat canned meat, fruit, vegetables, juices, powdered milk, soup, crackers, granola, and trail mix.

Clothes:

- Prepare one change of clothes and footwear per person.
- Consider adding blankets, rain gear, and outerwear for inclement weather.

Medications:

- Gather three days' worth of prescription medicines, noting expiration dates.

Flashlight:

- Keep a bright flashlight handy in case of power outages.
- Consider a lantern-style light for hands-free use; avoid candles due to fire hazards.

Can Opener:

- Ensure you have a manual can opener in case of power loss.
- Consider purchasing items with pull-top openings.

Radio:

- Have a battery-powered radio for news and weather updates.
- Stock up on extra batteries in advance.

Hygiene Items:

- Include basic hygiene items like soap, toilet paper, toothbrush, and moist towels for sanitation.

First Aid:

- Have essential first aid supplies such as antiseptic, gloves, bandages, and non-prescription medicines.
- Consider purchasing a pre-made first aid kit from a pharmacy or grocery store.

In Case of Emergency:

- **Dial 911 for immediate assistance.**

For further details on emergency planning, reach out to your local emergency office for Montgomery County at 301-579-4555.

PATIENT ADMISSION CONSENT FORM

INSTRUCTIONS: This form serves to confirm receipt of our patient admission booklet and affirms your comprehension and acceptance of its contents. Your signature below signifies your agreement.

CONSENT TO RECEIVE SERVICES:

I, _____, hereby authorize QUALITY ONE CARE HOME HEALTH, INC (QOC) to provide appropriate home care services to the patient named above. I understand that the care will be administered by qualified home care personnel. I acknowledge my right to refuse treatment or discontinue services at any time by notifying the QOC office. Additionally, I understand that QOC may terminate services by notifying me of such termination and the reason.

EMERGENCY MEDICAL SERVICES AUTHORIZATION:

During my receipt of services from QOC, I authorize QOC and its employees/contractors to administer or obtain necessary medical treatment in the event of a medical emergency.

I agree to assume sole responsibility for all charges associated with such treatment.

RELEASE OF MEDICAL RECORDS:

I understand that my Protected Information may be used or disclosed for treatment purposes during my care with Quality One Care Home Health Inc. This may involve various personnel accessing my information to ensure quality care.

I also acknowledge that protected health information may be disclosed to individuals involved in my care after discharge from QOC.

I acknowledge that QOC does not provide insurance coverage for damages to my automobile, bodily injury, or property damage resulting from the use of my automobile by QOC employees/contractors.

PATIENT BILL OF RIGHTS STATEMENT:

I acknowledge that I have received verbal and written information regarding the statement of rights and responsibilities, QOC grievances procedure, Department of Health Home Health Complaint Hotline number, notice of privacy practices, OASIS privacy Notes, Basic Home Safety, Emergency planning related to a disruption in service, and infection control. I confirm that this information has been explained to me to the best of my knowledge.

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself.

I Have Completed and Executed the Following:

- Living will Yes No
- Durable power of attorney Yes No
- Do Not Resuscitate Order Yes No
- Advance Directives Yes No

I certify that all information given by me to QOC is correct for requesting and applying for payment under Title XVIII (Medicaid/Medicare), Title XIX (Medicaid) of the Social Security Act, or from any third-party payer. I understand and agree to pay deductibles, co-payments, spend downs, and any amount due after payment of benefits on my behalf by all third-party payers.

I verify that I am not a participating member of an HMO (Health Maintenance Organization). If I enroll in one, I will immediately notify QOC.

I understand that services provided to me by QOC will be billed as follows:

- Medicare fee for service (Projected 100% covered). My Payment liability is \$0.00.
- Medicaid (Projected 100% covered after meeting spend down and/or other requirements). My Payment liability is \$0.00.
- Private insurance: Insurance coverage ___% Co-Pay ___%.
- Private pay (See private Pay Rate Sheet. Patient is responsible for the timely payment of all charges).

Patient/Authorized Representative Signature: _____

Date: _____

PRIVACY POLICY NOTIFICATION

****IMPORTANT: This Notice Outlines How Your Medical Information May Be Utilized or Disclosed and How You Can Access This Information. Please Review It Carefully.**

Our agency utilizes your Protected Health Information (PHI) for your treatment, payment processing, and operational purposes, such as enhancing the quality of care we offer. We are dedicated to upholding your confidentiality and safeguarding your health information. By law, we are mandated to provide you with this notice, detailing our health information privacy practices, including those of our affiliated healthcare providers.

This notice pertains to all information and records associated with your care that our agency workforce members and Business Associates have received or created. It also encompasses healthcare professionals and organizations providing care through our agency. It outlines potential uses and disclosures of your Protected Health Information and outlines your rights and our obligations concerning this information.

We Are Legally Obligated To:

- Maintain the confidentiality of your Protected Health Information.
- Provide you with this comprehensive Notice detailing our legal duties and privacy practices concerning your Protected Health Information.
- Adhere to the terms of this Notice currently in effect. We retain the right to amend the terms of this Notice, with notification to you or your personal representative by letter in the event of any material changes.

I. With Your Consent, We May Use and Disclose Your Protected Health Information for Treatment, Payment, And Healthcare Operations.

You will be requested to provide consent, allowing us to utilize and disclose your Protected Health Information to facilitate your treatment, secure payment for our services, and manage our healthcare operations.

Here are examples illustrating how we may use and disclose your health information:

- **For Treatment:** We may utilize or disclose your Protected Health Information for treatment purposes. During your care with Quality One Care Home Health Inc., various personnel involved in your care, such as physicians, nurses, nurses' aides, therapists, and consultants, may require access to your protected information to ensure the provision of quality care. For instance, patients with compromised immunity, communicable diseases, or any condition that spreads through contact, will have their diagnosis communicated to all personnel involved in their care. Additionally, we may disclose protected health information to individuals who will be participating in your care following your discharge from Quality One Care Home Health, Inc.
- **For Payment:** Our Agency may employ and disclose your Protected Health Information to facilitate billing for your health care services and obtain payment. For example, we may incorporate your health information into our claim submitted to your insurance company, Medicaid/Medicare, or Medicaid to secure payment for services rendered to you. We may also disclose your health information to other healthcare providers to facilitate payment.
- **For Health Care Operations:** We may utilize and disclose your Protected Health Information for the operational needs of our Agency. These uses and disclosures are essential for the efficient operation of our Agency and ensuring that all our patients receive quality care. For instance, we may use your health information to conduct reviews of our treatments and services, as well as to evaluate the performance of our staff or other contracted agencies such as laboratories.

II. We May Use and Disclose Your Protected Health Information for Other Specific Purposes

- **Business Associates:** We may share your Protected Health Information with our vendors and agents who handle PHI for certain functions or activities on behalf of the Agency. These are our "Business Associates." To ensure the protection of your health information, we require our Business Associates and their subcontractors to appropriately safeguard your information.

- **Family and Friends Involved in Your Care:** With your consent, we may disclose your Protected Health Information to a family member, close friend, or clergy who is involved in your care or payment for that care.
- **Disaster Relief:** We may disclose your Protected Health Information to organizations assisting in disaster relief efforts.
- **Personal Representative:** If you have a personal representative, such as a legal guardian, we will treat them as if they were you regarding disclosures of your health information. If you pass away, we may disclose health information to your estate's executor or administrator or to your next of kin, as permitted by law.
- **Public Health Activities:** We may disclose your Protected Health Information for public health activities, including disease reporting, public health surveillance, and intervention, as well as notifying individuals who may have been exposed to a communicable disease.
- **Health Oversight Activities:** Your Protected Health Information may be disclosed to health oversight agencies authorized by law to conduct audits, investigations, and licensure actions.
- **Reporting Victims of Abuse, Neglect, or Domestic Violence:** If we suspect that you have been a victim of abuse, neglect, or domestic violence, we may use and disclose your Protected Health Information to notify the appropriate authorities or with your consent.
- **Law Enforcement:** Your Protected Health Information may be disclosed for specific law enforcement purposes or other governmental functions.
- **Judicial and Administrative Proceedings:** Your Protected Health Information may be disclosed during certain judicial or administrative proceedings.
- **Research:** We will obtain your written authorization before using or disclosing your Protected Health Information for research purposes.
- **Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations:** We may release your health information to coroners, medical examiners, funeral directors, or organ procurement organizations. If you are an organ donor, your information may be disclosed to organizations involved in organ and tissue donation.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or

safety, or that of the public or another person. Such disclosures will only be made to individuals able to assist in preventing the threat.

- **Military and Veterans:** If you are a member of the armed forces, we may use and disclose your Protected Health Information as required by military command authorities. We may also disclose Protected Health Information about foreign military personnel as required by the appropriate foreign military authority.
- **Workers' Compensation:** We may use or disclose your Protected Health Information to comply with laws related to workers' compensation or similar programs.
- **National Security and Intelligence Activities; Protective Services:** We may disclose health information to authorized federal officials conducting national security and intelligence activities or as necessary to provide protection to the President of the United States or other important officials.
- **Marketing:** In most cases, we are required by law to obtain your written authorization before using or disclosing your health information for marketing purposes. Under no circumstances will we sell patient lists or health information to a third party without your prior written authorization.
- **As Required by Law:** We will disclose your Protected Health Information when mandated by law.

III. Your Authorization Is Required for Other Uses of Your Protected Health Information.

- We will use and disclose your Protected Health Information other than as described in this Notice or required by law only with your written Authorization. You may revoke your Authorization to use or disclose Protected Health Information in writing, at any time. To revoke your Authorization, contact the nursing department. If you revoke your Authorization, we will no longer use or disclose your Protected Health Information for the purposes covered by the Authorization, except where we have already relied on the Authorization.

IV. Your Rights Regarding Your Health Information

You have the following rights regarding medical information we maintain about you:

- **Request for Restrictions:** You may request in writing a restriction on certain uses or disclosures of your medical information for treatment, payment, or health care operations. While we will consider your request, we are not legally required to agree to it, except in

cases where you have paid out of pocket in full for a service and request a restriction on disclosure to a health plan. It is your responsibility to notify other providers about any agreed-upon restrictions.

- **Obtain a Paper Copy of Notice:** You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive it electronically. You can contact the Admitting or Registration Department to request a copy.
- **Inspect and Obtain a Copy of Medical Information:** In most cases, you have the right to inspect and obtain a copy of your medical information. If you request a copy (paper or electronic), we may charge you a reasonable, cost-based fee.
- **Request for Amendment:** You may request in writing an amendment to your records if you believe the information is incorrect or important information is missing. We may deny your request if the information was not created by us, is not maintained by us, or if we determine the record is accurate. In California, you have the right to appeal a decision by us not to amend your record in writing. Even if we deny your request for amendment, you have the right to submit a written addendum to your record.
- **Accounting of Disclosures:** You can request an accounting of disclosures stating who and where your medical information has been disclosed for purposes other than treatment, payment, health care operations, or where you specifically authorized a use or disclosure in the past six (6) years. After the first request, there may be a charge for additional requests made within a twelve (12) month period.
- **Request for Communication Preferences:** You may request that medical information about you be communicated to you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

V. Complaints

If you believe that your privacy rights have been violated, you may file a complaint in writing with our office by contacting the Quality Improvement Office at **301-658-7141**.

VI. Changes to This Notice

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice.

We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all Protected Health Information already received and maintained by the Agency as well as for all Protected Health Information we receive in the future. We will post a copy of the current Notice in the Agency. In addition, we will provide a copy of the revised Notice to all patients by mailing or hand-delivering a hard copy to them or their personal representatives as requested.

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the Director of Compliance/Privacy Officer at 301-658-7141.

I _____, acknowledge that I have been provided with a copy of Quality One Care Home Health Inc. private policy notification.

Signature: _____

Date: _____

OASIS PRIVACY NOTICE

Statement of Patient Privacy Rights

As a home health patient, you have these privacy rights:

- **You have the right to know why we need to ask you questions.**

We're required by law to collect health information to make sure you get quality health care, and that payment for Medicare and Medicaid patients is correct.

- **You have the right to have your personal health care information kept confidential.**

We may ask you to tell us information about yourself so that we'll know which home health services will be best for you. We keep anything we learn about you confidential. This means only those legally authorized or with a medical need to know will see your personal health information.

- **You have the right to refuse to answer questions.**

We may need your help to collect your health information. If you choose not to answer, we'll fill in the information as best we can. You don't have to answer every question to get services.

- **You have the right to look at your personal health information.**

It's important that the information we collect about you is correct. If you think we made a mistake, ask us to correct it. If you're not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services (the federal Medicare and Medicaid agency) to see, review, copy or correct your personal health information.

See the Privacy Policy Notification for more details about your privacy rights.

To see, review, copy, or correct your personal health information in federal records, call 1-800-MEDICARE (1-800-633-4227) for help contacting the HHA

PATIENT PROFILE

DNR (Do Not Resuscitate): YES NO

Location: _____

EMERGENCY CONTACT

Full Name:

Relationship:

Phone Number:

YOUR HOME CARE TEAM

Nurse:

Physical Therapist:

Nurse:

Occupational Therapist:

Home Health Aide:

Speech Therapist:

Quality One Care Home Health, Inc.
9221 Colesville Road, Silver Spring, MD 20910
Tel: 301-658-7141 | Fax: 301-579-4845

IMPORTANT AGENCY INFORMATION

For inquiries about your home care, scheduling, visit changes, or to voice concerns, please feel free to contact us via mail or phone at the details provided below.

Quality One Care always have someone available to assist you 24 hours a day, 7 days a week.

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9221 Colesville Road,
Silver Spring, MD 20910

Tel: 301-658-7141
Fax: 301-579-4845
Email: info@qualityonecare.com
Web: www.qualityonecare.com

EXHIBIT 6

Patient Rights & Responsibilities / Grievance Policy

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS
Patient Rights and Responsibilities Policy

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

PH: 301 658-7141 / Fax: 301 658-2328

QOC Patient Rights & Responsibilities Policy

I. PURPOSE

The purpose of this policy is to affirm and protect the rights of all patients receiving care from Quality One Care Home Health, Inc. (QOC), and to ensure that patients understand their responsibilities in the care process. QOC is committed to delivering care that is respectful, compassionate, person-centered, culturally sensitive, and compliant with all federal and state regulations.

II. POLICY STATEMENT

QOC believes that every patient deserves to be treated with dignity, respect, fairness, and kindness. All patients have fundamental rights related to autonomy, privacy, informed decision-making, safety, communication, and participation in their healthcare. These rights apply regardless of race, color, ethnicity, national origin, religion, gender, sexual orientation, disability, age, diagnosis, socioeconomic status, or payer source.

QOC will protect and promote patient rights at all times and ensure that patients understand both their rights and their responsibilities in receiving high-quality home health care.

III. REGULATORY COMPLIANCE

This policy complies with:

- CMS Conditions of Participation (42 CFR §484.50 – Patient Rights)
- COMAR 10.07.10.17 (Client Rights, Confidentiality, and Grievances)
- COMAR 10.24.16 (Home Health Agency Standards – Quality and Patient Protection)
- Maryland Patients' Bill of Rights
- Joint Commission standards (RI.01.01.01 through RI.01.07.01)
- HIPAA Privacy and Security Rules



IV. SCOPE

This policy applies to:

- All QOC staff, contractors, and volunteers
- All clinical services and service locations
- All patients and caregivers served by QOC
- All communication and documentation related to care

V. PHILOSOPHY

QOC believes:

- Patients are partners in care.
- Informed choices lead to better outcomes.
- Respect for culture, values, and preferences is essential.
- Transparency builds trust.
- Listening to patients improves quality.
- Protecting rights is a moral, legal, and professional obligation.

VI. PATIENT RIGHTS

Every patient receiving services from QOC has the right to:

1. Be treated with dignity, respect, and compassion

- Receive care without discrimination or prejudice.
- Be free from verbal, mental, physical, or sexual abuse.
- Be free from neglect, exploitation, or retaliation.
- Receive considerate and respectful care in a safe environment.

2. Be informed and make decisions about their care

- Receive a clear explanation of their condition, treatments, services, and care plan.
- Participate in developing and revising the plan of care.
- Be informed of expected outcomes, risks, and alternatives.
- Give or withhold informed consent.
- Refuse treatment, to the extent permitted by law, and be informed of consequences.

3. Know their caregivers

- Know the name and role of each person providing care.

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- Expect that all staff are properly trained and credentialed.
- Request a change of caregiver, when possible and appropriate.

4. Confidentiality and privacy (HIPAA rights)

- Have all health information protected and kept confidential.
- Approve or deny the release of medical information, except when required by law.
- Receive a copy of the Notice of Privacy Practices.
- Access and request corrections to their medical record.

5. Receive care in a safe, timely, and coordinated manner

- Care delivered according to professional standards.
- Services that are free from unnecessary delay.
- Continuity of care through transitions and discharge.

6. Be free from financial exploitation or inappropriate charges

- Receive a clear explanation of services and charges.
- Be informed of any out-of-pocket costs before services start.
- Be informed of financial assistance, charity care, and payment options.

7. Choose their provider

- Select QOC or any other qualified home health provider.
- Be informed of alternative providers when QOC cannot meet needs.
- Transfer to another agency at any time.

8. Voice complaints or grievances without fear

- File a complaint about care, staff, safety, or any concern.
- Have complaints taken seriously and resolved promptly.
- Be free from retaliation, punishment, or service reduction.
- Submit grievances anonymously if desired.
- Escalate concerns to state agencies or accrediting bodies.

Contact information for grievances will be provided in writing.

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9. Appeal decisions (including Medicare rights)

- Receive proper written notice of discharge (NOMNC).
- Request an expedited appeal through Medicare or appropriate entity.
- Continue receiving covered services during the appeal, when permitted by law.

10. Receive information in a way they understand

- In their preferred language (interpreter services provided).
- Use alternative formats if visually or hearing impaired.
- Receive written and verbal explanations of rights and policies.

11. Designate representatives and make advance directives

- Choose a representative or caregiver to assist in care decisions.
- Create or provide an advance directive or living will.
- Expect staff to honor advance directives and end-of-life decisions as permitted by law.
- Change or withdraw directives at any time.

12. Expect ethical, culturally competent, non-discriminatory care

- Equal treatment regardless of background or payer.
- Cultural, spiritual, and personal values respected.
- Reasonable accommodation of preferences when possible.
- Ethical issues addressed through proper channels.

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VII. GRIEVANCE PROCEDURE (Required by CMS & COMAR)

Patients may file a grievance **verbally or in writing** to any staff member. QOC will:

- Acknowledge receipt promptly.
- Investigate fairly and objectively.
- Maintain confidentiality.
- Provide a written response with findings and resolution.
- Document and track grievances in the QAPI program.
- Use findings to improve systems and care.

No patient will be penalized or discharged for filing a grievance.

Patients may also contact the Maryland Department of Health, Medicare, or The Joint Commission directly. QOC will provide contact numbers and addresses in writing.

VIII. PATIENT RESPONSIBILITIES

To support safe, effective care, patients and caregivers are expected to:

- Provide accurate and complete health information.
- Inform QOC of changes in health, medications, or contact information.
- Follow the agreed-upon plan of care.
- Ask questions if instructions are not understood.
- Notify QOC if unable to keep appointments.
- Maintain a safe home environment for care delivery.
- Treat staff with respect and courtesy.
- Participate in decision-making.
- Provide necessary supplies or equipment when required by payor.
- Notify QOC or physician of concerns or dissatisfaction.
- Pay agreed-upon fees or make financial arrangements.

IX. COMMUNICATION OF PATIENT RIGHTS

QOC will explain patient rights:

- Verbally and in writing.
- In the patient's preferred language.
- At or before the start of services.
- To the patient and/or representative.
- With documentation that the patient received and understands their rights.

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Rights are also:

- Included in admission packets.
- Posted at the agency office (if applicable).
- Available upon request to the public.

X. NON-RETALIATION GUARANTEE

QOC strictly prohibits retaliation or reduction in services due to:

- Filing a grievance
- Refusing treatment
- Requesting a second opinion
- Exercising any patient right

Any retaliation will result in corrective action.

XI. STAFF TRAINING

All staff receive training on patient rights:

- During orientation
- Annually as part of ongoing education
- When regulations or policies change
- Training includes cultural competence, privacy, communication, and grievance processes.

Staff must uphold and protect patient rights at all times.

XII. DOCUMENTATION

QOC will document:

- Delivery of patient rights information (signed acknowledgement)
- Any grievances and resolutions
- Patient representative designation (when applicable)
- Advance directives and code status
- Medicare notices (NOMNC, ABN, etc.)
- Patient refusal of services or treatment

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XIII. POLICY REVIEW AND APPROVAL

This policy will be:

- Reviewed at least annually
- Updated as needed based on regulatory changes or QAPI findings
- Approved by the Governing Body
- Communicated to all staff

EXHIBIT 7

HIPAA PRIVACY & CONFIDENTIALITY

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS
HIPAA Privacy & Confidentiality Policy
Documentation & Record-Keeping Policy
Notice of Privacy Practices (NPP)
Record Retention & Destruction Policy

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9221 Colesville Road, Silver Spring, MD 20910

Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

HIPAA PRIVACY & CONFIDENTIALITY POLICY

1. PURPOSE

The purpose of this policy is to establish privacy and confidentiality requirements for Quality One Care Home Health, Inc. (QOC) to protect the privacy of individuals receiving services and to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and applicable federal and state confidentiality requirements.

This policy applies to all patients served by QOC's Home Health Agency operations and protects individually identifiable health information ("Protected Health Information" or "PHI") in any form or medium (paper, electronic, oral).

2. POLICY STATEMENT

QOC maintains the confidentiality, integrity, and availability of all PHI and will:

- Use and disclose PHI only as permitted or required by law and QOC policy.
- Limit uses and disclosures of PHI to the **minimum necessary** to accomplish the intended purpose (except where HIPAA permits otherwise).
- Implement administrative, physical, and technical safeguards to protect PHI.
- Provide patients with the **HIPAA Notice of Privacy Practices (NPP)** and honor patient privacy rights as required by HIPAA.
- Train staff on HIPAA privacy requirements and enforce sanctions for violations.
- Investigate and report privacy incidents and breaches as required by HIPAA/HITECH.

3. SCOPE

This policy applies to:

- All QOC workforce members (employees, volunteers, students, interns)
- Contractors and vendors who may access PHI (Business Associates)

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- Any individual acting on behalf of QOC in patient care, billing, quality assurance, and administrative operations
- All PHI created, received, maintained, or transmitted by QOC, including clinical records, billing records, electronic health records (EHR), and communications

4. DEFINITIONS

Protected Health Information (PHI): Individually identifiable health information maintained or transmitted by QOC in any form.

Electronic PHI (ePHI): PHI created, stored, transmitted, or received electronically.

Business Associate: A person or entity that performs functions on behalf of QOC involving PHI (e.g., billing vendors, EHR vendor).

Minimum Necessary: A HIPAA standard requiring reasonable effort to limit PHI access/use/disclosure to the least amount needed.

Breach: An impermissible use or disclosure of PHI presumed to be a breach unless a risk assessment demonstrates a low probability of compromise.

5. ROLES AND RESPONSIBILITIES

➤ 5.1 Privacy Officer

QOC designates a Privacy Officer responsible for:

- Oversight of HIPAA privacy compliance
- NPP distribution and updates
- Responding to patient privacy requests and complaints
- Training coordination
- Incident response and breach management

Privacy Officer Name/Title: [Insert Name/Title]

Phone: [Insert Phone]

Email: [Insert Email]

➤ 5.2 Security Officer (ePHI)

QOC designates a Security Officer responsible for:

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- Safeguards for ePHI (technical controls, access management)
- Security incident response coordination
- Coordination with IT/EHR support and vendors

Security Officer Name/Title: [Insert Name/Title]

Phone: [Insert Phone]

Email: [Insert Email]

➤ **5.3 Workforce Responsibilities**

All workforce members must:

- Protect PHI and maintain confidentiality
- Follow access controls and do not share logins
- Report privacy incidents immediately
- Complete required HIPAA training
- Use secure communication methods

6. PERMITTED USES AND DISCLOSURES OF PHI

QOC may use or disclose PHI without patient authorization for the following purposes:

➤ **6.1 Treatment**

Use or disclosure of PHI to provide, coordinate, or manage patient care, including coordination with physicians, hospitals, pharmacies, and other health care providers.

➤ **6.2 Payment**

Use or disclosure of PHI to obtain payment for services, including claims submission, eligibility verification, billing, collections consistent with policy, and coordination with insurers.

➤ **6.3 Health Care Operations**

Use or disclosure of PHI for QOC operations including quality assessment and improvement, peer review, audits, accreditation, compliance reviews, staff training, licensing and certification activities, and business planning.

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➤ **6.4 Required by Law**

Use or disclosure of PHI when required by federal, state, or local law (e.g., public health reporting, abuse/neglect reporting).

➤ **6.5 Public Health and Safety**

Use or disclosure for public health activities, communicable disease reporting, and preventing or reducing a serious and imminent threat, consistent with HIPAA.

➤ **6.6 Business Associates**

QOC may disclose PHI to Business Associates only when:

- A **Business Associate Agreement (BAA)** is in place; and
- The Business Associate is required to protect PHI and report breaches.

➤ **6.7 Family and Caregivers**

QOC may share relevant PHI with family members or caregivers involved in the patient's care, consistent with HIPAA and patient preference, and as documented by QOC.

7. USES AND DISCLOSURES REQUIRING AUTHORIZATION

QOC must obtain written patient authorization prior to using/disclosing PHI for:

- Marketing purposes (unless permitted under HIPAA)
- Sale of PHI
- Most disclosures of psychotherapy notes (if applicable)
- Any purpose not otherwise permitted under HIPAA

Patients may revoke authorization in writing at any time, except to the extent action has already been taken in reliance on the authorization.

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8. MINIMUM NECESSARY STANDARD

QOC will apply the minimum necessary standard to uses/disclosures and access to PHI, except for:

- Uses/disclosures for treatment
- Disclosures to the patient
- Uses/disclosures authorized by the patient
- Disclosures required by law or to HHS for compliance

9. PATIENT RIGHTS UNDER HIPAA

QOC honors the following rights as required under HIPAA:

➤ 9.1 Right to Receive NPP

Patients will receive QOC's Notice of Privacy Practices at or before the first service delivery and will acknowledge receipt.

➤ 9.2 Right to Access PHI

Patients may request access to their medical record and obtain copies within timelines required by law.

➤ 9.3 Right to Request Amendment

Patients may request correction or amendment of PHI; QOC will respond in writing in accordance with HIPAA.

➤ 9.4 Right to Request Restrictions

Patients may request restrictions on certain uses/disclosures. QOC will evaluate requests; some restrictions may not be required.

➤ 9.5 Right to Request Confidential Communications

Patients may request communication through alternative means (e.g., phone vs mail).

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➤ **9.6 Right to an Accounting of Disclosures**

Patients may request a record of certain disclosures as required by HIPAA.

➤ **9.7 Right to File a Complaint**

Patients may file complaints without fear of retaliation with QOC or with the U.S. Department of Health and Human Services (HHS) Office for Civil Rights.

10. SAFEGUARDS FOR PHI

QOC will maintain safeguards to protect PHI:

➤ **10.1 Administrative Safeguards**

- Workforce training and confidentiality agreements
- Role-based access to PHI
- BAAs with vendors
- Incident reporting procedure
- Sanctions policy for violations

➤ **10.2 Physical Safeguards**

- Secure storage of paper records
- Controlled access to offices/records
- Visitor control procedures
- Secure disposal of PHI

➤ **10.3 Technical Safeguards (ePHI)**

- Unique user IDs and password protections
- Multi-factor authentication where available
- Audit logs and access monitoring
- Encryption where applicable
- Secure remote access and device management

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11. BREACH REPORTING AND INCIDENT RESPONSE

➤ 11.1 Immediate Reporting

All workforce members must report suspected privacy incidents or breaches immediately to the Privacy Officer.

➤ 11.2 Investigation

The Privacy Officer will investigate each incident and determine whether it constitutes a breach. QOC will conduct a HIPAA risk assessment considering:

- Nature and extent of PHI involved
- Unauthorized person who received PHI
- Whether PHI was actually acquired/viewed
- Extent to which risk was mitigated

➤ 11.3 Notification

If a breach is confirmed, QOC will provide required notices in accordance with HIPAA/HITECH, including:

- Notice to affected individuals without unreasonable delay and within required timelines
- Notice to HHS and, where applicable, media notification

12. TRAINING AND SANCTIONS

➤ 12.1 Training

QOC provides HIPAA privacy training:

- Upon hire/onboarding and prior to PHI access
- Annually thereafter
- When policies change or new risks are identified

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➤ **12.2 Sanctions**

Violations of this policy may result in disciplinary action up to and including termination, and may result in civil or criminal penalties under HIPAA.

13. RECORD RETENTION

QOC retains privacy-related documentation including:

- NPP acknowledgments
- authorizations
- disclosures logs
- complaints and resolutions
- training logs
- breach investigations and notifications

Retention will comply with QOC record retention standards and applicable law.

14. COMPLAINTS AND CONTACT INFORMATION

Patients may file privacy complaints by contacting:

QOC Privacy Officer

Phone: 301-658-7141

Email: info@qualityonecare.com

Address: 9221 Colesville Road, Silver Spring, MD 20910

Patients may also file a complaint with the U.S. Department of Health and Human Services (HHS) Office for Civil Rights.

15. RELATED POLICIES / REFERENCES

- Notice of Privacy Practices (NPP)
- Documentation & Record-Keeping Policy

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- Record Retention & Destruction Policy
- Patient Rights & Responsibilities Policy
- Incident Reporting Policy
- Business Associate Agreement (BAA) policy/procedure

16. APPROVAL

Approved by: _____

Name/Title: _____

Date: _____

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DOCUMENTATION AND RECORD-KEEPING POLICY

Purpose

To establish comprehensive agency-wide standards for accurate, timely, and complete documentation of all care and services provided to participants under Model Waiver and Private Duty Nursing (PDN), ensuring continuity of care, regulatory compliance, and legal protection. This policy ensures compliance with:

- **COMAR 10.09.53** — Home Health Services (Model Waiver/PDN)
- **COMAR 10.27** — Nursing Practice Act (Delegation & Standards)
- **HIPAA** — Health Insurance Portability and Accountability Act)
- **Maryland Department of Health (DOH) & DONS guidelines**

Scope

This policy applies to all staff engaged in documenting participant care, including:

- Skilled Nurses (RNs, LPNs, CNAs)
- Clinical Staff (PTs, OTs, STs & MSWs)
- Administrative (DON, RN Supervisors, Case Managers Schedules & Intake)

Policy Statement

All clinical documentation is a legal record of the care we provide. It serves as the primary tool for ensuring continuity of care, justifying services, and verifying regulatory compliance.

Every entry must be a **clear, factual, and chronological account** of the participant's condition, the services delivered, and communication with the participant and their caregivers.

1. All documentation must be **accurate, legible, timely, and complete.**
2. Entries must clearly reflect:
 - Participant condition and response to care
 - Interventions performed and outcomes
 - Caregiver communication and participation
 - Refusals, preferences, or incidents
 - Education provided and caregiver's understanding
3. Supervisory notes must demonstrate **in-person visits**, caregiver engagement, and oversight of delegated tasks.
4. All records are the **property of the agency**, protected under HIPAA and DOH retention and confidentiality rules.

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Documentation Procedures

1. Daily Documentation/Charting by Direct Care Staff

Your daily notes are the most important record of a participant's progress. They must be completed **before the end of your shift** and include:

- **Care Provided:** Document all medications, treatments, personal care (ADLs), and key observations.
- **Changes in Condition:** Note any new or changing physical, mental, or emotional symptoms. Include any concerns reported by the participant or their caregiver.
- **Communication:** Record participant and caregiver input, questions, or concerns. Use direct quotes for important statements.
- **Refusals or Deviations:** Clearly document any instance where the participant or caregiver refuses a service or requests a deviation from the plan of care.
- **Education:** Note any education you provide on topics like medication side effects, infection control, or equipment use, and confirm the listener's understanding.

2. Supervisory Visit Documentation

RN Supervisors must conduct **in-person visits at least every 45 days**. The supervisory note must confirm:

- An assessment of the participant's overall health, safety, and home environment.
- Direct observation of delegated tasks performed by LPNs/RNs.
- A review of the Plan of Care to ensure it's being followed correctly and compliance.
- An interview with the caregiver to discuss their satisfaction, concerns, and any requests.

Caregiver Signature: Whenever possible, obtain the caregiver's signature to acknowledge the visit. If they are unavailable, **document the reason why** (e.g., "Caregiver was at a doctor's appointment and unavailable to sign").

3. General Documentation Standards

- **Identify Yourself:** Every entry must include the date, time of service, your full name, your professional title and signature/initials.
- **Documentation:** Must be completed before the end of each shift.
- **Correcting Errors:** To fix a mistake, draw a single line through the error, write "error," and add your initials and the date. Never use white-out or scribble over an entry.
- **Use Approved Abbreviations Only:** A list of approved abbreviations is available. If you're unsure, write it out.

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4. Confidentiality & HIPAA Compliance

Protecting participant information is everyone's responsibility.

- **Secure Records:** All clinical records, whether paper or electronic, must be kept confidential and secured from unauthorized access.
- **Safeguard Credentials:** Use the agency's provided Electronic Health Record (HER) system. Never share your login information for the Electronic Health Record (EHR) system. Caregivers may only review records relevant to their family member, per HIPAA.
- **Be Aware of Your Surroundings:** All documentation must comply with security protocols. Never leave documentation visible in your car or any public area – never leave documentation unattended in public view.

5. Documentation During Emergencies

In an emergency, **immediate participant care is the first priority**. As soon as the situation is stable, document the following:

1. The events that occurred.
2. The interventions you performed.
3. Everyone you notified (e.g., 911, family, supervisor, agency).
4. The outcome.

After documenting in the participant's chart, you must also complete an **incident report** per agency policy. Complete a separate incident report for each incident.

6. Audits & Quality Assurance

Documentation is regularly reviewed to ensure we meet our standards for quality and compliance.

- **RN Supervisors** conduct monthly chart audits to verify compliance with COMAR, HIPAA, and agency policies:
 - Completeness of notes
 - Caregiver involvement
 - Supervisory visit documentation
- The **QA/Compliance Officer** performs quarterly reviews to identify trends, risks and/or areas for improvement to ensure compliance with COMAR, HIPAA and DOH rules.

Audits are used to identify opportunities for **coaching, retraining, and enhancing our quality of care**. Deficiencies may lead to corrective action, including retraining or disciplinary measures.

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7. Staff Responsibilities

- **Direct Care Staff (RNs, LPNs):** Maintain complete, real-time documentation.
- **Supervisory RNs:** Ensure caregiver involvement is reflected in documentation; verify staff and staff documentation is compliant.
- **Compliance/QA Officer:** Monitor adherence through audits; recommend corrective action as needed.
- **Agency Leadership & Management:** Provide training, tools, and support to ensure compliance.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR RESPONSIBILITIES

QOC is required by law to:

- Maintain the privacy and security of your Protected Health Information (“PHI”).
- Provide you with this Notice of Privacy Practices describing our legal duties and privacy practices.
- Follow the terms of the Notice currently in effect.
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your information.

PHI is information that may identify you and relates to your health condition, the health care services you receive, or payment for those services.

HOW WE MAY USE AND DISCLOSE YOUR PHI (WITHOUT YOUR WRITTEN AUTHORIZATION)

We may use and disclose your PHI for the following purposes:

➤ Treatment

We may use and share your PHI to provide, coordinate, or manage your home health care.

Example: sharing information with your physician, hospital, pharmacy, or other providers involved in your care.

QOC Quality One Care



Home Health, Inc

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➤ **Payment**

We may use and share your PHI to bill for services and receive payment from health plans or other payers.

Example: submitting claims to Medicare, Medicaid, or private insurance, or verifying coverage.

➤ **Health Care Operations**

We may use and share your PHI for business operations, quality assessment, training, compliance activities, and program improvement.

Example: chart reviews, audits, internal performance improvement, accreditation, and licensing activities.

➤ **Family Members, Caregivers, and Personal Representatives**

We may share relevant PHI with family members or other persons involved in your care, consistent with your preferences and applicable law, unless you object.

➤ **Required by Law**

We may disclose your PHI when required to do so by federal, state, or local law.

➤ **Public Health and Safety Activities**

We may disclose your PHI for public health activities (such as reporting certain diseases) and to protect public safety, as permitted by law.

➤ **Abuse, Neglect, or Domestic Violence**

We may disclose PHI to authorized government agencies if we believe you may be a victim of abuse, neglect, or domestic violence, as required or permitted by law.

➤ **Health Oversight Activities**

We may disclose PHI to oversight agencies for activities such as audits, investigations, inspections, and licensure actions.

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➤ **Judicial and Administrative Proceedings**

We may disclose PHI in response to a court order, subpoena, discovery request, or other lawful process, as permitted by law.

➤ **Law Enforcement**

We may disclose PHI to law enforcement officials as required or permitted by law.

➤ **Research**

We may use or disclose PHI for research purposes as permitted by HIPAA, subject to required safeguards.

➤ **Coroners, Medical Examiners, and Funeral Directors**

We may disclose PHI as needed to identify a deceased person, determine cause of death, or carry out duties required by law.

➤ **Organ and Tissue Donation**

We may disclose PHI to organizations that handle organ procurement or transplantation, as permitted by law.

➤ **Workers' Compensation**

We may disclose PHI for workers' compensation or similar programs as permitted by law.

➤ **Serious Threat to Health or Safety**

We may disclose PHI if necessary to prevent or reduce a serious and imminent threat to the health or safety of you or another person, as permitted by law.

➤ **Business Associates**

We may disclose PHI to vendors who assist us (e.g., billing services, EHR vendors). These Business Associates are required by contract and law to protect your information.

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USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will obtain your written authorization before using or disclosing your PHI for:

- Marketing purposes (unless permitted by HIPAA)
- Sale of PHI
- Most disclosures of psychotherapy notes (if applicable)
- Any other purpose not described in this Notice

You may revoke your authorization at any time in writing, except to the extent we have already acted on it.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights:

1) Right to Get a Copy of Your Medical Record

You may request access to or copies of your medical record and other health information we have about you.

We will provide a copy or summary in the format you request, if readily available, within the timeframe required by law. We may charge a reasonable, cost-based fee.

2) Right to Request a Correction (Amendment)

If you believe your information is incorrect or incomplete, you may request that we amend it. We may deny the request, but we will provide a written explanation.

3) Right to Request Confidential Communications

You may request that we contact you in a specific way (for example, at work, by phone only, or by mail to a different address). We will accommodate reasonable requests.

4) Right to Ask Us to Limit What We Use or Share

You may request restrictions on certain uses/disclosures. We are not required to agree to every request.

If you pay for a service in full out of pocket, you may request that we not share information about that service with your health plan (unless required by law).

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5) Right to Get a List of Disclosures (Accounting of Disclosures)

You may request a list of certain disclosures of your PHI we have made in the past six years (excluding disclosures for treatment, payment, and operations, and certain other disclosures). We will provide one accounting per 12-month period at no charge.

6) Right to Get a Copy of This Notice

You may request a paper copy of this Notice at any time, even if you have agreed to receive it electronically.

7) Right to Choose Someone to Act for You

If you have designated a medical power of attorney or legal guardian, that person may exercise your rights and make choices about your information, as appropriate and as documented.

CHANGES TO THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all PHI we maintain. The revised Notice will be available upon request and on our website.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with QOC or with the U.S. Department of Health and Human Services (HHS) Office for Civil Rights.

QOC will not retaliate against you for filing a complaint.

Contact QOC Privacy Officer

Privacy Officer

Phone: (301) 658-7141

Email: privacy@qualityonecare.com

Mailing Address: 9221 Colesville Road, Silver Spring, MD 20910

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ACKNOWLEDGMENT OF RECEIPT (FOR ADMISSION PACKET)

I acknowledge that I received a copy of the **Notice of Privacy Practices** from Quality One Care Home Health, Inc.

Patient Name: _____

Patient/Representative Signature: _____

Relationship (if representative): _____

Date: _____

Staff Member Name/Title: _____

Staff Signature: _____

Date: _____

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RECORD RETENTION & SECURE DESTRUCTION POLICY

1. PURPOSE

The purpose of this policy is to establish record retention and secure destruction standards for Quality One Care Home Health, Inc. (QOC) to ensure compliance with applicable federal and state requirements, including HIPAA/HITECH, Medicare Conditions of Participation (where applicable), and payer contract requirements, and to protect the confidentiality and integrity of patient and business records.

2. POLICY STATEMENT

QOC retains clinical, administrative, and financial records for minimum retention periods outlined in this policy and disposes of records securely to protect Protected Health Information (PHI) and confidential business information. Records will be retained in a manner that ensures they are complete, accessible, and protected from unauthorized access, alteration, or destruction.

3. SCOPE

This policy applies to:

- All patient medical records (paper and electronic)
- Billing and financial records
- Staff/personnel records
- Quality assurance and compliance records
- Incident reports and grievance files
- Contracts, policies, and governing body records
- Any record containing PHI or confidential business information

This policy applies to all workforce members, contractors, and vendors who create, maintain, store, access, or destroy QOC records.

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4. DEFINITIONS

- **Record:** Any document, file, electronic record, email, image, audio, or other medium containing clinical, financial, or operational information.
- **PHI:** Protected Health Information as defined by HIPAA.
- **Secure Destruction:** A method of disposal that renders records unreadable, indecipherable, and incapable of reconstruction.
- **Legal Hold:** A directive to preserve records relevant to actual or anticipated litigation, investigation, audit, or claim.

5. RETENTION STANDARDS

➤ 5.1 General Rule

Unless a longer period is required by law, payer contract, audit requirement, or legal hold, QOC will retain records for the minimum periods listed below. If multiple requirements apply, the **longest retention period** will be followed.

➤ 5.2 Minimum Retention Periods

QOC will retain records according to the following minimum standards:

A. Patient Medical Records (Clinical Records)

- **Adult patient medical records: 7 years** from the date of discharge/last date of service
- **Minor patient medical records: 7 years after the patient reaches the age of majority (18) or 7 years after discharge**, whichever is longer

B. Billing, Claims, and Financial Records

- Claims, remittances, payment records, EOBs, invoices: **7 years**
- Accounts receivable records, payment plans, charity care determinations: **7 years**
- Cost reports and supporting documentation (if applicable): **10 years**

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C. Medicare/Medicaid Program Integrity & Audit Records

- Records supporting reimbursement, audits, and investigations: **10 years** (or longer if required by payer/auditor)

D. Personnel / HR Records

- Employment applications, hiring documents, evaluations, training records: **7 years after separation**
- Credentialing, licensure, competency records: **7 years after separation**
- Payroll records (minimum): **7 years**

E. Incident, Complaint, and Grievance Records

- Incident reports, adverse events, complaints, grievances: **7 years**

F. Quality Assurance / QAPI Records

- QAPI committee minutes, performance improvement projects, audit logs: **7 years**

G. Policies, Procedures, and Governing Body Records

- Policies/procedures (retained with revision history): **7 years after retirement of the policy**
- Governing body minutes and official corporate records: **Permanent** (recommended)

H. Contracts, Vendor Agreements, and BAAs

- Contracts, referral agreements, BAAs: **7 years after termination/expiration**

6. STORAGE AND SECURITY REQUIREMENTS

➤ 6.1 Paper Records

Paper records must be stored securely in locked cabinets or secured rooms with controlled access. Records must not be left unattended in public areas, vehicles, or unsecured locations.

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➤ 6.2 Electronic Records

Electronic records must be stored in approved systems (EHR, secure file storage) with:

- Role-based access controls
- Unique user IDs and password protections
- Audit logs where available
- Encryption in transit and at rest where feasible
- Regular backup and disaster recovery procedures

➤ 6.3 Access Control

Access to records is limited to authorized personnel with job-related need. Sharing credentials is prohibited. QOC maintains a process for timely removal of access upon termination.

7. LEGAL HOLDS

If QOC becomes aware of an actual or anticipated audit, investigation, litigation, complaint, or claim, the Administrator or Privacy Officer may issue a **Legal Hold** requiring immediate suspension of destruction for relevant records. Records under legal hold must be retained until the hold is released in writing.

8. SECURE DESTRUCTION STANDARDS

Records may only be destroyed once:

1. The retention period has expired, **and**
2. The record is not subject to a legal hold, audit, investigation, or open claim, **and**
3. Destruction is authorized by the Administrator or designee.

➤ 8.1 Paper Record Destruction

Paper records containing PHI or confidential information must be destroyed by:

- Cross-cut shredding, **or**
- Secure shredding vendor service with documented chain-of-custody

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➤ **8.2 Electronic Record Destruction**

Electronic records must be destroyed using methods that render data unrecoverable, including:

- Secure deletion and data wiping consistent with NIST standards where feasible
- Physical destruction of media (hard drives, USB devices) when needed
- Vendor destruction certificates (where applicable)

➤ **8.3 Disposal of Devices**

Devices (computers, tablets, phones) used for patient care or business operations must be securely wiped prior to disposal, repurposing, or return to leasing vendors.

9. DOCUMENTATION OF DESTRUCTION

QOC will maintain a **Record Destruction Log** documenting:

- Record type destroyed
- Date range covered
- Date of destruction
- Method of destruction
- Person/vendor performing destruction
- Authorization signature/initials

Vendor services must provide a certificate of destruction upon request.

10. TRAINING AND COMPLIANCE

QOC will train all workforce members on record confidentiality, retention, secure storage, and destruction procedures:

- Upon hire
- Annually thereafter
- When policies are updated or new risks are identified

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Violations of this policy may result in disciplinary action, up to and including termination, and may result in civil or criminal penalties under HIPAA.

11. RESPONSIBILITIES

- **Administrator:** Oversight of implementation and approvals for destruction
- **Privacy Officer:** Privacy compliance, breach reporting, audits, and training coordination
- **Security Officer / IT:** ePHI safeguards, secure wipe procedures, access controls
- **Billing Department:** Retention of financial and patient responsibility records
- **Supervisors:** Ensuring staff compliance and secure documentation practices

12. RELATED POLICIES

- HIPAA Privacy & Confidentiality Policy (Exhibit 7A)
- Documentation & Record-Keeping Policy (Exhibit 7B)
- Notice of Privacy Practices (Exhibit 7C)
- Patient Rights & Responsibilities Policy (Exhibit 6)
- Incident Reporting and Compliance Reporting Policies

EXHIBIT 8

Service Integration Plan

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS
Scope of Services & Service Delivery Model Policy



QOC Scope of Services & Service Delivery Model Policy

I. Purpose

The purpose of this policy is to define the full scope of home health services offered by Quality One Care Home Health, Inc. (QOC) and to describe the structured, patient-centered model by which these services are delivered, coordinated, and monitored. This policy ensures that all care provided by QOC is safe, evidence-based, high-quality, and compliant with applicable laws, regulations, and clinical standards.

II. Regulatory Compliance

This policy ensures compliance with:

- CMS Conditions of Participation for Home Health Agencies (42 CFR Part 484)
- COMAR 10.24.16 – Home Health Agency Standards
- COMAR 10.07.10 – State Licensing Regulations for HHAs
- Maryland State Health Plan (access, quality, continuity)
- Joint Commission Home Care Accreditation Standards
- Medicare Conditions of Participation (Plan of Care, Skilled Services, Coordination of Care, OASIS)
- HIPAA and OSHA standards

III. Philosophy of Care

QOC operates according to the following principles:

- **Patient-centered:** Care is individualized based on the patient's needs, goals, and preferences.
- **Physician-directed:** All skilled services are provided under a physician-ordered plan of care.
- **Interdisciplinary:** Care is delivered by a coordinated team of nurses, therapists, social workers, and aides.
- **Evidence-based:** Services follow clinical guidelines and best practices.
- **Outcome-driven:** Success is measured by improvement, safety, satisfaction, and quality of life.
- **High-acuity capable:** QOC is equipped to manage complex, medically fragile, and pediatric patients.
- **Culturally competent and equitable:** QOC serves all patients with respect and removes barriers to care.

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- **Continuous improvement:** Quality is supported by QAPI, data monitoring, and performance evaluation.

IV. Scope of Services Provided

QOC delivers the **full continuum of Medicare-certified home health services**, including but not limited to:

1. Skilled Nursing (RN/LPN)

- Comprehensive assessments (OASIS, head-to-toe, functional, psychosocial)
- Medication management & reconciliation
- IV therapy (antibiotics, hydration, TPN)
- Enteral feeding & tube management
- Tracheostomy/ventilator care
- Wound care (including complex, negative pressure, post-surgical)
- Chronic disease management (CHF, COPD, diabetes, dementia, hypertension)
- Foley catheter care
- Pain management
- Vital signs and symptom monitoring
- Patient and caregiver education
- Telehealth-supported monitoring (when appropriate)
- 24/7 RN on-call support

2. Therapy Services

Physical Therapy (PT):

- Mobility and strength training
- Gait training & balance
- Post-surgical rehab
- Fall prevention programs
- Pain management strategies
- Home safety assessments

Occupational Therapy (OT):

- Activities of Daily Living (ADLs)
- Fine motor and cognitive skills
- Adaptive equipment training
- Energy conservation techniques
- Environmental modifications

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Speech Therapy (ST):

- Speech and language rehabilitation
- Swallowing evaluations and therapy
- Cognitive-communication training
- Voice therapy

3. Medical Social Work (MSW)

- Psychosocial assessments
- Counseling and emotional support
- Advance care planning and goals of care
- Resource coordination (housing, food, transportation)
- Long-term care planning
- Crisis intervention
- Support for family/caregivers

4. Home Health Aide (HHA) / Personal Care

- Personal hygiene (bathing, grooming, dressing)
- Mobility and transfer assistance
- Vital signs under RN supervision
- Exercise assistance
- Light homemaking and meal prep (as permitted)
- Skin care and prevention of pressure ulcers
- Observation and reporting of condition changes

All aide services are **supervised by an RN or therapist** per CMS requirements.

5. High-Acuity Specialty Programs (QOC Strength)

QOC specializes in complex, medically fragile patients:

- Ventilator and tracheostomy care
- Complex wound care (stage 3/4, negative pressure therapy)
- Enteral and parenteral nutrition
- IV infusion therapy
- Neurologic conditions (stroke, TBI, SCI)
- Respiratory failure
- Oncology/home chemo coordination (if ordered)
- Sepsis recovery management

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6. Pediatric Home Health Services

- Skilled pediatric nursing (RN/LPN)
- Tracheostomy/vent care in children
- Seizure monitoring and neuro care
- Congenital condition management
- Chronic illness management (e.g., muscular dystrophy, diabetes)
- Developmental milestone support (with therapy)
- Caregiver training and support
- School coordination (as appropriate)
- Emotional and psychosocial support for families

QOC hires or trains clinicians with **pediatric-specific expertise**.

7. Chronic Disease Management Programs

QOC offers structured, evidence-based programs for:

- **Congestive Heart Failure (CHF)**
- **Chronic Obstructive Pulmonary Disease (COPD)**
- **Diabetes**
- **Hypertension**
- **Dementia / Alzheimer's**
- **Parkinson's Disease**
- **Post-COVID recovery**
- **Post-surgical transitions**
- **Palliative care coordination (non-hospice)**

Each program includes:

- Symptom monitoring
- Red-flag education
- Self-management support
- Medication adherence
- Dietary counseling
- Telehealth as appropriate
- Readmission prevention strategies



8. Additional Services / Capabilities

- Medication blister packing coordination
- Dietitian services (if available)
- Remote monitoring and telehealth
- Caregiver training and competency checks
- Transitional care and post-hospital support
- Behavioral health referrals
- Case management
- Palliative/hospice care coordination
- Community resource linkage

V. Service Delivery Model

QOC follows a **structured, interdisciplinary, patient-centered model** of service delivery:

1. Referral & Intake

- Referrals accepted from hospitals, physicians, payors, community, and self-referrals
- Eligibility and insurance verified
- Clinical appropriateness assessed
- High-acuity needs flagged
- Start of Care scheduled promptly (within 48h or sooner)

2. Initial Assessment

- Performed by RN or qualified therapist (OASIS when required)
- Comprehensive assessment of medical, functional, psychosocial, and safety needs
- Identification of risks (falls, readmission, infection, high-acuity)
- Education and goal-setting with patient/family

3. Plan of Care (POC)

- Developed with patient/caregiver input
- Ordered and signed by physician
- Includes frequency, duration, interventions, goals, and target outcomes
- Updated at least every 60 days or as needed

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4. Interdisciplinary Care

- Each discipline follows the POC
- Coordination via case conferences, EMR, and real-time communication
- RN Case Manager leads coordination for high-acuity or complex patients

5. Visit Frequency

Determined by:

- Physician order
- Clinical need and acuity
- Evidence-based protocols
- Regulatory requirements
- Patient/caregiver capacity

Visits may be increased for instability or reduced as goals are met.

6. High-Acuity Management

- More frequent monitoring
- Specialized staff (trained RN/LPN)
- Technology support (telehealth, remote monitoring)
- 24/7 on-call support
- Escalation plan if condition worsens

7. Telehealth Integration

Telehealth may be used to:

- Supplement in-person care
- Monitor vitals and symptoms
- Provide education and follow-up
- Improve access in rural areas

Telehealth does not replace required in-person visits unless permitted by CMS/payer.

8. Caregiver & Patient Education

- Disease and symptom management
- Medication safety
- Equipment and device training
- Emergency contact and escalation
- Preventive strategies (falls, infection)

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- Self-care and independence promotion

9. Coordination with External Providers

- Regular communication with physicians
- Collaboration with hospitals (post-discharge planning)
- Referrals to specialists or community services
- Coordination with DME, pharmacy, and MSW for support
- Warm handoffs when transitioning to other care levels

10. Discharge Planning

Begins at admission and includes:

- Achievement of goals
- Transition to self-care or caregiver support
- Referral to other providers (SNF, outpatient, hospice)
- Notification to physician
- Written discharge summary (within 5 business days)
- Follow-up call to ensure smooth transition

VI. Quality, Safety, And Continuity

QOC ensures high-quality service delivery through:

- Competency-based staffing
- Clinical supervision and case management
- Routine chart audits and documentation reviews
- QAPI program (data-driven improvement)
- Patient satisfaction surveys (QOC 98%+ historically)
- Monitoring of key performance indicators (readmissions, falls, infection, timeliness, outcomes)
- Emergency preparedness integration
- Health equity and access tracking
- Technology and data analytics to optimize care

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VII. Limitations and Exclusions

QOC does **not** provide:

- 24-hour in-home private duty care
- Non-medical transportation
- Long-term custodial care without skilled component
- Services outside clinical scope or licensure
- Experimental or non-evidence-based treatments

If a service cannot be provided:

- QOC will inform the patient and referral source
- Provide alternative provider options
- Assist in safe transfer when needed

VIII. Review & Approval

This policy will be:

- Reviewed at least annually
- Updated based on regulatory changes, QAPI findings, clinical best practices, or service expansion
- Approved by the Administrator / Governing Body
- Communicated to all staff upon revision

EXHIBIT 9

**Quality Assurance and Assurance
Improvement (QAPI) Program**

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George’s County,
Calvert County, Charles County & St. Mary’s County

CONTENTS
Quality Assurance Policy
QAPI Supportive Documents



QOC Quality Assurance and Performance Improvement (QAPI) Program & Policy

I. PURPOSE

The purpose of the Quality Assurance & Performance Improvement (QAPI) Program is to ensure that Quality One Care Home Health, Inc. (QOC) consistently delivers safe, effective, patient-centered, high-quality home health services and continuously improves clinical outcomes, patient experience, and operational performance across all service areas and patient populations.

This QAPI Program is designed to:

- Fully comply with **CMS Conditions of Participation (42 CFR §484.65)**
- Meet the **Maryland State Health Plan standards (COMAR 10.24.16.08 – Quality)**
- Satisfy **COMAR 10.24.01.08G(3)(f) – Quality Review Criteria**
- Align with **Joint Commission Home Care Accreditation Standards**
- Support QOC’s mission to provide **evidence-based, high-performing, equitable care**

QOC is committed to serving **adult and pediatric patients**, including those with **high-acuity or medically complex needs**, and will not refuse admission based on complexity, disability, or ability to pay.

II. POLICY STATEMENT

QOC maintains an agency-wide, data-driven QAPI Program that is:

- Ongoing and proactive
- Led by administrative and clinical leadership
- Supported by all staff and disciplines
- Focused on measurable quality indicators and patient outcomes
- Linked to strategic goals, regulatory standards, and patient needs
- Driven by data, patient feedback, staff input, and regulatory requirements
- Designed to continuously improve performance, prevent problems and sustain excellence



III. SCOPE

This QAPI Program applies to:

- All departments and disciplines
- All clinical programs (skilled nursing, therapy, high-acuity care, pediatric care, chronic disease programs, etc.)
- All service lines and locations (existing and new)
- All payor types (Medicare, Medicaid, commercial, private pay, etc.)
- All patient populations (adult, pediatric, medically complex, underserved)
- All aspects of operations that impact care quality and patient experience

III. GOVERNANCE & RESPONSIBILITY

1. Governing Body

The Governing Body (or Administrator/Executive Leadership) holds ultimate responsibility for:

- QAPI design, implementation, and results
- Allocating adequate resources (staff, time, data systems, training)
- Approving QAPI goals and Performance Improvement Projects (PIPs)
- Reviewing QAPI quarterly and annual reports
- Holding leadership accountable for outcomes
- Ensuring QAPI aligns with strategic priorities and regulatory obligations

2. QAPI Committee

The QAPI Committee meets **at least quarterly** and includes:

- Administrator / Executive Director
- Director of Nursing / Clinical Director
- Therapy Supervisor(s)
- Quality Improvement Coordinator / QAPI Nurse
- Medical Director or physician advisor (as needed)
- Representatives from nursing, therapy, MSW, and home health aides
- Representatives from intake/scheduling/billing as appropriate

Responsibilities:

- Analyze quality data and trends
- Review patient outcomes and satisfaction
- Evaluate compliance with clinical standards and regulatory measures
- Identify opportunities for improvement

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- Select and monitor PIPs
- Develop and track corrective action plans
- Report findings to the Governing Body

3. Management & Supervisors

Department leaders are responsible for:

- Monitoring discipline-specific quality indicators
- Educating and supervising staff
- Ensuring protocol compliance
- Implementing corrective actions
- Reporting issues to the QAPI Committee

4. All Staff Members

All employees participate in QAPI by:

- Delivering high-quality care
- Reporting incidents, near misses, and concerns
- Following policies and best practices
- Participating in training and improvement projects
- Supporting a culture of safety, accountability, and excellence

QAPI is embedded in daily operations — not a separate function.

V. QAPI PROGRAM STRUCTURE

QOC's QAPI Program includes four required components as defined by CMS:

1. Performance Measurement

Systematic collection and analysis of data in:

- Clinical outcomes
- Patient safety events
- Operational efficiency
- Patient experience & satisfaction
- Staff competency and retention
- Regulatory compliance

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2. Performance Improvement Activities

When opportunities or problems are identified, QOC:

- Conducts root cause analysis (RCA)
- Develops and implements corrective actions
- Re-measures performance
- Ensures sustained improvement

3. Performance Improvement Projects (PIPs)

Data-driven, interdisciplinary projects that focus on:

- High-risk, high-volume, or problem-prone processes
- Critical quality concerns or strategic priorities
- Patient safety, access, or outcome improvements

4. Continuous Feedback & Integration

QAPI activities lead to:

- Policy and procedure updates
- Staff training
- Operational changes
- Technology enhancements
- Resource allocation
- Long-term strategic planning

VI. QUALITY INDICATORS & DATA SOURCES

QOC collects both quantitative and qualitative data, including:

Clinical Outcomes (examples):

- Wound healing rates
- Improvement in functional ability
- Pain management effectiveness
- Medication reconciliation accuracy
- CHF/COPD/diabetes outcomes
- OASIS outcome measures
- High-acuity case success metrics (vent/trach/IV)

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Patient Safety:

- Falls and fall-related injuries
- Infection rates (wound, line sepsis, etc.)
- Adverse events or medical errors
- Hospitalizations and ED visits (especially 30-day readmissions)
- Timeliness of interventions and follow-up

Operational Performance:

- Time from referral to admission (48-hour standard)
- Same-day or next-day start of care rate
- Visit frequency compliance
- Missed or canceled visits
- Staff productivity and caseload
- Scheduling efficiency

Patient Experience:

- Patient satisfaction surveys (98% historical performance)
- Family/caregiver feedback
- Complaint/grievance tracking
- Net promoter scores (if used)

Staff & Workforce:

- Staff retention and turnover
- Competency validation results
- Training completion rates
- Staff satisfaction and culture assessments

Regulatory Compliance:

- CMS process measures (e.g., timely initiation of care)
- State requirements (COMAR)
- Joint Commission standards
- Documentation audit results



VII. HEALTH EQUITY & ACCESS MONITORING

QOC actively monitors access and outcomes to ensure care is **equitable and effective** across:

- Geographic areas
- Age groups (including pediatric vs adult)
- Disability or functional status
- Socioeconomic status / payor type
- Race / ethnicity / language
- Medically underserved or rural populations

When disparities are identified, QOC implements targeted interventions (e.g., outreach, staff education, telehealth expansion, partnerships with local providers).

VIII. USE OF TECHNOLOGY & DATA ANALYTICS

QOC leverages technology to enhance quality:

- **Electronic Health Record (EHR)** with integrated clinical alerts, documentation audits, and outcomes tracking
- **Clinical dashboards** to monitor real-time performance
- **Telehealth and remote monitoring** to support high-acuity, rural, and chronic care populations
- **Data analytics tools** to identify trends, predict risks, and support early intervention
- **Secure communication platforms** to coordinate interdisciplinary care and reduce delays

Technology supports **faster decisions, better coordination, and improved patient safety.**

IX. PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

A. Purpose of PIPs

Performance Improvement Projects are **targeted, data-driven initiatives** aimed at improving specific aspects of care with the greatest impact on:

- Patient outcomes
- Safety
- Access
- Satisfaction
- Regulatory compliance
- Strategic goals



B. Criteria for Selecting PIPs

PIPs are initiated when:

- Quality data reveals below-target performance
- A process is high-risk or high-volume
- A problem is persistent or trending negatively
- Regulatory requirements indicate focus
- Staff, patient, or caregiver feedback identifies issues
- Strategic priorities or innovation opportunities arise

C. Examples of PIPs QOC May Conduct:

- Reduce 30-day hospital readmission rates (CHF, COPD, wound infections)
- Improve admission timeliness (48-hour or same-day starts)
- Strengthen medication reconciliation accuracy
- Improve caregiver education and competency in high-acuity cases
- Increase wound healing rates
- Decrease missed or canceled visits
- Enhance pediatric tracheostomy or ventilator care outcomes
- Improve documentation completeness and timeliness
- Increase patient satisfaction scores beyond 98%

D. PIP Methodology

Each PIP follows a structured improvement model:

1. Define the problem with data
2. Establish measurable goals/outcomes
3. Form an interdisciplinary PIP team
4. Conduct root cause analysis (e.g., fishbone, 5 Whys)
5. Develop and implement interventions
6. Measure progress regularly
7. Modify interventions as needed
8. Sustain successful improvements
9. Report to QAPI Committee and Governing Body

E. Minimum Requirement

At least **one PIP at all times**, as required by CMS.

QOC typically conducts **multiple PIPs simultaneously** to drive improvement across key areas.

X. USE OF QAPI TO DRIVE RESOURCES & STAFFING

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QOC uses QAPI findings to inform:

- Staffing levels and caseload distribution
- Specialized clinical training needs
- Recruitment of high-acuity and pediatric specialists
- Investment in telehealth, remote monitoring, and data systems
- Scheduling and workflow optimization
- Budget allocation for quality initiatives
- Development or expansion of specialty programs

Quality drives operational decision-making at QOC.

XI. VALUE-BASED CARE & INNOVATION

QOC aligns QAPI with **Home Health Value-Based Purchasing (HHVBP)** measures, including:

- Improvement in ambulation
- Improvement in self-care
- Medication management
- Hospital readmission reduction
- Patient experience (satisfaction and communication)
- Timely initiation of care

QOC also uses QAPI to:

- Adopt evidence-based best practices
- Pilot new care models (e.g., advanced chronic care programs)
- Scale successful initiatives across all service areas
- Drive efficiency without sacrificing care quality

QOC views QAPI as an engine for innovation, not just compliance.

XII. PATIENT SAFETY & RISK MANAGEMENT

QOC uses a comprehensive safety program that includes:

- Incident and near-miss reporting (non-punitive culture)
- Investigation and root cause analysis (RCA)
- Corrective action implementation
- Regular safety rounds (field observations, case reviews)
- Fall and injury prevention strategies
- Medication safety protocols

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- Infection surveillance and control
- Emergency preparedness drills
- Staff safety training and reporting mechanisms

High-risk events are reported to the Governing Body and monitored for trends.

XIII. STAFF EDUCATION & COMPETENCY

QAPI findings directly inform staff training, including:

- Orientation and annual competencies
- High-acuity skills (vent/trach, wound, IV, pediatric)
- Documentation accuracy
- Cultural competence and health equity
- Emergency preparedness
- Ethics and patient rights
- Regulatory changes and best practices

QOC ensures:

- Competency checklists are validated
- Staff receive ongoing education
- Performance issues lead to targeted retraining or coaching
- High performers are recognized and used as preceptors/mentors

XIV. DOCUMENTATION & REPORTING

QOC maintains comprehensive records of:

- QAPI Committee meetings
- Quarterly performance dashboards
- Data trend reports and analysis
- Identified issues and improvement actions
- PIP charters, interventions, and outcomes
- RCA findings and action plans
- Staff training related to QAPI
- Annual QAPI Program evaluation

Documentation is maintained in a secure, organized manner and is available to CMS, state surveyors, and accrediting bodies.

XV. ANNUAL QAPI PROGRAM EVALUATION

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Every year, QOC conducts a formal QAPI Program Evaluation that includes:

- Review of quality indicators and trends
- Summary of PIPs conducted and outcomes
- Analysis of goals met and unmet
- Identification of emerging risks or gaps
- Assessment of resource sufficiency
- Staff competency and training needs
- New priorities for the next year
- Recommendations for policy or operational changes
- Approval by Governing Body

XVI. CULTURE OF QUALITY & CONTINUOUS IMPROVEMENT

QOC promotes a culture where:

- Quality is everyone's responsibility
- Data drives decisions
- Patient safety is non-negotiable
- Transparency is expected
- Improvement is continuous
- Success is celebrated
- Innovation is encouraged
- Patients, families, and staff are heard

QOC does not aim to be minimally compliant —

QOC strives to be a leader in clinical excellence, patient satisfaction, and operational performance.

XVII. POLICY REVIEW & APPROVAL

This QAPI Program and Policy is reviewed **at least annually** and updated to ensure continued alignment with:

- CMS Conditions of Participation (42 CFR 484.65)
- COMAR 10.24.16.08 Quality standards & Best practices in home health care
- Joint Commission requirements

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Annual Client Survey: Hand Hygiene Technique Compliance

Survey Year: _____

Client Name: _____

Date of Observation: _____

Staff Completing Form: _____

Instructions: This survey is designed to evaluate the understanding and application of proper hand hygiene practices among clients and their family members. Please complete each item by checking the appropriate box. Your participation helps us improve the quality of care provided.

1. Education & Understanding

- I received verbal and/or written instruction on proper handwashing techniques.
- I understand when handwashing is required (e.g., before/after care, meals, restroom use).
- I was educated on the differences between handwashing with soap and using hand sanitizer.
- I understand how hand hygiene helps prevent infections and protects my loved one.

2. Skill Demonstration (To Be Completed with Staff Observation)

- I demonstrated how to wash hands using soap and water, covering all hand surfaces for at least 20 seconds.
- I demonstrated how to use alcohol-based hand sanitizer appropriately when soap and water are not available.
- I performed hand hygiene before and after participating in patient care activities during the observation.
- Observed and Verified by Staff

3. Application and Compliance

- I am able to demonstrate proper hand washing technique.
- I have access to clean water, soap, and paper towels at home.
- I use hand hygiene consistently during daily routines and caregiving.
- I encourage other caregivers/family members to follow hand hygiene protocols.

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4. Feedback

- I feel confident in my ability to maintain good hand hygiene.
- I would benefit from additional training or materials on hand hygiene.
- I am satisfied with the training provided by the agency.

5. Additional Comments (Optional)

Client/Family Member Name: _____

Signature: _____

Date: _____

Staff Reviewer Initials: _____

Date Reviewed: _____

****Confidentiality Notice:**

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Annual Client Survey: Tracheostomy Suctioning Techniques

Survey Year: _____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: Client Family Member Other (Specify): _____

Instructions:

Please review the following items with the client or family caregiver. Check each box that applies. This form should be completed during initial training and reviewed annually or as needed.

1. Understanding of Suctioning Equipment Use

- Able to identify suction machine and its parts
- Can assemble suction equipment correctly
- Demonstrates knowledge of appropriate suction pressure settings
- Understands when and how often to suction

2. Demonstration of Proper Technique

- Performs hand hygiene before and after suctioning
- Uses appropriate Personal Protective Equipment (PPE)
- Measures catheter insertion depth accurately
- Suctions tracheostomy tube correctly (using circular motion, ≤ 10 seconds per pass)
- Allows sufficient recovery time between suction passes

3. Safety and Emergency Readiness

- Recognizes signs of respiratory distress
- Knows when to stop suctioning and call for medical help
- Keeps spare tracheostomy supplies readily available
- Able to describe steps for accidental decannulation

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4. Post-Suctioning Care

- Cleans suction catheter or uses disposable appropriately
- Properly discards waste and used supplies
- Ensures tracheostomy ties are secure
- Monitors for secretions, bleeding, or skin breakdown around the stoma

5. Client/Family Confidence

- Verbalizes understanding of procedure
- Demonstrates confidence in performing suctioning independently
- Agrees to contact nurse if unsure or if changes are noticed

Nurse/Staff Reviewer Initials: _____

Client/Family Signature: _____

Date of Completion: _____

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Annual Client Survey: Medication Management Education

Survey Year: _____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: Client Family Member Other (Specify): _____

PART 1: Medication Education

1. Were you educated on how to take your medications safely?
 Yes No Not sure
2. Do you understand the purpose of each medication you are currently taking?
 Yes, completely Somewhat No
3. Were written instructions (e.g., medication list or schedule) provided to you?
 Yes No Not Sure
4. Were you informed about potential side effects of your medications?
 Yes No Not Applicable
5. Do you know what to do or who to contact if you experience side effects?
 Yes No Unsure

PART 2: Medication Management Support

6. Do you use a pill organizer or reminder system (e.g., phone alert, caregiver)?
 Yes No Not Needed
7. Did someone assist you with medication setup (sorting pills, creating schedule, etc.)?
 Yes No Not Applicable
8. Have your nurses or caregivers reviewed your medication list with you regularly?
 Yes, every visit Sometimes No
9. Do you feel confident managing your medications independently or with help?
 Yes No I need more training
10. How satisfied are you with the medication education provided?
 Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied
11. Would you like additional support or follow-up regarding your medications?
 Yes No

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PART 3: Feedback and Suggestions

12. How would you rate the clarity and usefulness of the medication management education you received?

- Very clear and helpful
- Somewhat helpful
- Not helpful
- I did not receive education

13. Do you have any suggestions on how we can improve our medication management education and support?

Signature: _____

Staff Reviewer Initials: _____

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Annual Client Survey: Home Oxygen Safety

Survey Year: _____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: Client Family Member Other (Specify): _____

PART 1: Oxygen Safety Training Completion

1. Did you (or your caregiver) receive education from a nurse or respiratory therapist on how to safely use and store oxygen at home?
 Yes No Not Sure
2. Was this training provided at the start of care or during your first oxygen setup visit?
 Yes No Don't Remember
3. Were written materials (handouts, checklists, or posters) provided to you on oxygen safety?
 Yes No Not Sure
4. Were you educated on the importance of avoiding smoking or open flames near oxygen?
 Yes No Don't Remember
5. Did the staff check where and how the oxygen tanks were stored in your home?
 Yes No Not Applicable

PART 2: Confidence and Knowledge Retention

6. On a scale of 1 to 5, how confident do you feel about safely using and storing oxygen in your home?
 1 – Not Confident
 2 – Somewhat Confident
 3 – Neutral
 4 – Confident
 5 – Very confident
7. Do you know what to do in case of an oxygen-related emergency or equipment failure?
 Yes No Not Sure
8. Do you know how to clean and maintain your oxygen equipment (if applicable)?
 Yes No N/A – Maintenance handled by provider

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PART 3: Feedback and Suggestions

9. Do you believe the training you received was:

- Easy to understand
- Too basic
- Too complicated
- Not applicable to your situation

10. Do you have any suggestions for improving how we provide oxygen safety training?

Signature: _____

Staff Reviewer Initials: _____

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Annual Client Survey: Fall Prevention

Survey Year: _____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: Client Family Member Other (Specify): _____

PART 1: Fall Prevention Education Completion

1. Did you receive education from a nurse or therapist on how to prevent falls at home?
 Yes No Not Sure
2. Was this training provided during your admission or within the first few days of service?
 Yes No Don't Remember
3. Were you given written materials (handouts or visual aids) on fall prevention?
 Yes No Not Sure
4. Did the staff discuss common household hazards that increase fall risk (e.g., loose rugs, poor lighting, uneven surfaces)? Yes No Not Sure
5. Did the nurse or staff make recommendations for home modifications (e.g., grab bars, non-slip mats, clutter removal)? Yes No Not Applicable

PART 2: Confidence and Fall History

6. Have you or your caregiver made changes to your home environment to reduce fall risks?
 Yes No In Progress Not Applicable
7. On a scale of 1 to 5, how confident do you feel about avoiding falls in your home?
 1 – Not Confident
 2 – Somewhat Confident
 3 – Neutral
 4 – Confident
 5 – Very confident
8. Since beginning care with our agency, have you experienced any falls?
 No falls One fall More than one fall Prefer not to say

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PART 3: Feedback and Suggestions

9. How would you rate the clarity and usefulness of the fall prevention education you received?

- Very clear and helpful
- Somewhat helpful
- Not helpful
- I did not receive education

10. Do you have any suggestions on how we can improve our fall prevention education and support?

Signature: _____

Staff Reviewer Initials: _____

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Annual Client Survey: Feeding Tube Insertion Demonstration

Survey Year: _____

Client Name: _____

Date of Observation: _____

Staff Completing Form: _____

Instructions: This survey is designed to assess your understanding and ability to demonstrate safe and accurate feeding tube insertion. Please complete the checklist below. Your feedback helps us maintain and improve our quality of care.

1. Feeding Tube Insertion Demonstration

Please check the box for each step that you or your caregiver feel confident in performing correctly after receiving education/training:

- Washed hands thoroughly before the procedure
- Verified the correct placement of the tube before use
- Flushed the tube with the appropriate solution prior to feeding
- Administered the correct formula and volume as directed
- Maintained proper positioning during and after the feeding
- Recognized signs of tube displacement or complications
- Cleaned the insertion site and equipment properly
- Documented feedings or reported to the nurse as instructed
- Felt comfortable asking questions or requesting help
- Understood the emergency steps in case of aspiration or blockage

2. Overall Understanding and Confidence

Please check the box that best represents your experience:

- I feel very confident performing this task independently
- I feel somewhat confident but may need occasional help
- I do not feel confident and need additional training

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3. Additional Comments (Optional)

Client/Parent/Guardian Name: _____

Signature: _____

Date: _____

Staff Reviewer Initials: _____

Date Reviewed: _____

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Annual Staff Audit: Home Equipment Maintenance/Cleaning Compliance

Audit Year: _____

Client Name: _____

Date of Visit: _____

Staff Completing Form: _____

Instructions: This form should be completed by field staff conducting home visits. Please review each applicable equipment item for maintenance, cleanliness, and functionality. Select all that apply. Signature required at the end.

1. Equipment Inventory (Check all present in the home)

- Oxygen Concentrator
- Nebulizer
- Suction Machine
- Feeding Pump
- Pulse Oximeter
- Wheelchair / Walker
- Bed Rails / Hospital Bed
- Other (Specify): _____

2. Maintenance Compliance (Check all that apply)

- All equipment is clean and free of visible dust, mold, or residue.
- Equipment is stored in a safe, accessible location.
- Power cords and tubing are free from damage or frays.
- Disposable parts (filters, masks, tubes) have been replaced on schedule.
- Manufacturer's guidelines for cleaning/maintenance are being followed.
- No foul odors, rust, or leakage detected.
- Client/family was reminded about routine equipment checks.

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3. Corrective Actions (if applicable)

- Client/family was educated on cleaning schedule
- Malfunctioning equipment was reported to agency or DME vendor
- Maintenance issue resolved during visit
- Follow-up visit scheduled
- Not applicable

4. Comments / Observations

Staff Signature: _____

Date: _____

Reviewer Initials: _____

Date Reviewed: _____

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Hazard Vulnerability Assessment Completion Survey

Audit Year: _____

Client Name: _____

Date of Visit: _____

Nurse/Staff Completing Assessment: _____

1. Hazard Identification (Check all that apply in the client's home environment)

- Fire hazards (e.g., faulty wiring, unattended candles, overloaded outlets)
- Slip/trip hazards (e.g., loose rugs, cluttered walkways, wet floors)
- Inadequate lighting (especially near stairways or bathrooms)
- Unsecured medical equipment or tubing
- Poor ventilation or exposure to smoke/allergens
- Hazardous chemicals or substances accessible to children/vulnerable adults
- Pets that may pose fall risks or cause allergic reactions
- Lack of functioning smoke or carbon monoxide detectors
- Unsafe storage of medication or sharp objects
- Unclear emergency exits or blocked paths
- Other (Specify): _____

2. Client Education Topics Reviewed (Check all completed)

- Emergency preparedness (fire, medical, evacuation plan)
- Proper use and storage of medical equipment
- Fall prevention strategies
- Safe medication handling and disposal
- Environmental safety and cleanliness
- When and how to call emergency services
- Infection control measures (e.g., hand hygiene, disinfection)
- Other: _____

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3. Client/Family Understanding

- Client/family understood hazard risks
- Client/family verbalized understanding of mitigation strategies
- Client/family demonstrated safe practices

4. Recommendations Made

Nurser/Staff Signature: _____

Date: _____

Reviewer Initials: _____

Date Reviewed: _____

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Annual Client Satisfaction Survey

Survey Year: _____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: Client Family Member Legal Representative Other: _____

Instructions:

Please review each statement below and check the box that best reflects your level of satisfaction. Your feedback is confidential and helps us improve our services.

How do you feel?	Very Satisfied	Satisfied	Neutral	Dissatisfied
Staff are respectful and professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff arrive on time for scheduled visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication with the agency is easy and responsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My care plan is explained clearly and updated as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel safe and cared for by the staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My needs are met in a timely and respectful manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am informed about my medications and treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The agency addresses my complaints or concerns promptly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agency and staff are knowledgeable and professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with the overall quality of services received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. Do you feel receiving services in your home?

Yes No Maybe

2. Overall, how satisfied are you with the services provided by Quality One Care?

Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied

3. What do you like most about our services?

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4. What could we do to improve our care or services?

5. Additional comments or suggestions

Client/Representative Signature: _____

Date: _____

Staff Reviewer Initials: _____

Date Reviewed: _____

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HAND HYGIENE OBSERVATIONS REPORT

NUMBER OF HAND HYGIENE PERFORMED: 40
PERIOD JANUARY - APRIL 2021
Compliance: 95 % Goal: 85% Goal Met <input type="checkbox"/> Yes <input type="checkbox"/> No

GOAL
National Average 75%
State Average 80%
Agency Goal 85%

OXYGEN CYLINDER STORAGE COMPLIANCE OBSERVATION FORM

This report should include the 3 month period of data collection.

Period:						Goal Met <input type="checkbox"/> Yes <input type="checkbox"/> No	
Compliance:						Goal:	
RN, LPN		HHA/CNA/PCA		Total			
Yes	No	Yes	No	Yes			
						=	
						+	

GOAL
Agency Goal 98%

Formula

$$\text{Compliance} = \frac{\text{Oxygen storage/handling compliance}}{\text{Number of activities}} \times 100$$

OXYGEN SAFETY TRAINING

PT NAME:		DOB:	DATE: 1/10/2022
O2 RELATED DIAGNOSIS:		CODE STATUS: Choose an item.	
ALLERGIES:			
<p>IS THIS: <input type="checkbox"/> Initial Teaching <input type="checkbox"/> Reassessment</p> <p>OXYGEN SUPPLY USED AT HOME: <input type="checkbox"/> Compressed oxygen cylinders, or "green tanks" <input type="checkbox"/> Oxygen concentrators <input type="checkbox"/> Liquid oxygen systems</p> <p>MEANS OF OXYGEN DELIVERY: <input type="checkbox"/> Nasal cannula <input type="checkbox"/> Ventilator <input type="checkbox"/> Mask <input type="checkbox"/> Trach collar</p> <p>TEACHING PROVIDED <input type="checkbox"/> Placing No smoking Oxygen in Use signs <input type="checkbox"/> Handling and storage of oxygen cylinders <input type="checkbox"/> Hazards of smoking with oxygen in use <input type="checkbox"/> Importance of securing electric devices to prevent short-circuit sparks. <input type="checkbox"/> Danger of using volatile, flammable materials near the patient using oxygen</p> <p>TEACHING PROVIDED TO: <input type="checkbox"/> Patient <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Family member <input type="checkbox"/> Other</p> <p>TYPE OF TEACHING: <input type="checkbox"/> Instructed <input type="checkbox"/> Supervised <input type="checkbox"/> Independent <input type="checkbox"/> Return demonstration.</p> <p>TEACHING TOOLS: <input type="checkbox"/> Verbal <input type="checkbox"/> Video <input type="checkbox"/> Demonstration <input type="checkbox"/> Printed material <input type="checkbox"/> other:</p> <p>RESPONSE TO TEACHING <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> anxious <input type="checkbox"/> Cannot cope.</p> <p>VERBAL /UNDERSTAND <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>NEED FURTHER SUPERVISION IN: NEED FURTHER INSTRUCTION IN: PLAN FOR NEXT TRAINING:</p> <p>DATE:</p>			

EQUIPMENT CLEANING LOG

NAME OF THE PATIENT _____ **DOB** _____

EQUIPMENT TO CLEAN /CHANGED	HOW OFTEN	DATE CLEANED	PROPER CLEANSER USED Yes/No	EQUIPMENT WAS CHECKED Yes /No	EQUIPMENT FUNCTION WELL Yes/No	INITIALS
Suction machine	Once a week					
Suction canister	Once a week					
Suction Tubing	Once a week					
Ventilator	Once a week					
Ventilator Tubing	Once a week					
Vent. Water Chamber	Once a week					
CPAP/BIPAP	Once a week					
CPAP/BIPAP tubing	Once a week					
Monitors	Once a week					
Nebulizer	Once a week					
Aerosol Tubing	Once a week					
Oxygen Tank	Once a week					
Oxygen Tubing	Once a week					
Oxygen Concentrator	Once a week					
Tracheostomy Tube	Once a week					
Feeding Pump	Once a week					
IV infusion pump	Once a week					
Wheel chair	Once a month					
Patient bed & furniture	Once a month					
Hoyer lift	Once a month					
Refrigerator	Once a month					
Medication cart	Once a month					
Toys	Once a month					

NAME	INITIALS	NAME	INITIALS

FALL REDUCTION PROGRAM

Reducing the risk of patient harm from falls is one of the National Patient Safety Goals established by the Joint Commission. Quality one care (QOC) has implemented a fall reduction program that provides guidelines for staff involved in the care of patients in the agency. The program not only limits the number of falls but also to minimize injury resulting from falls. Some key components of QOC's fall reduction program are:

- Fall Risk Assessment for each patient
- Environmental Assessment
- Staff education and training
- Education for patient & family
- Review of patient medications
- Individualized patient care plan
- Post-Fall Assessments
- Evaluation

QOC will measure the effectiveness of the program quarterly

The agency's comprehensive fall reduction program includes restraint-free tools to:

- Identify high fall risk patients
- Alert caregivers of a potential fall
- Hip protectors and floor cushions to reduce the risk of fall-related injuries
- Patient Safety tools to reduce the hazards within the patient's environment

FALL-REDUCTION PROGRAM EVALUATION

RISK CONTROL MEASURES	YES/NO	CORRECTIVE ACTION
<p>RISK ASSESSMENT PROCESS</p> <ol style="list-style-type: none"> 1. Is every client evaluated for risk of falling, utilizing a fall-assessment tool that considers the following factors, among others: <ul style="list-style-type: none"> • Previous fall history and associated injuries? • Gait and balance disturbances? • Foot and leg problems? • Reduced vision? • Medical conditions and disabilities? • Cognitive impairment? • Bowel and bladder dysfunction? • Special toileting requirements? • Use of multiple prescription and over-the-counter medications? • Need for mechanical and/or human assistance? • Environmental hazards? 2. Are higher-risk clients identified, including those who experience recurrent falls or have multiple risk factors? 3. Are higher-risk clients referred to their physician for a more thorough assessment? 4. Is a home safety check conducted prior to commencement of services? 5. If safety problems are detected in the home, are corrective actions recommended to the client as part of the service agreement? 6. Are direct care staff members involved in the initial client assessment, as well as ongoing reassessment efforts? 7. Are services regularly assessed and modified in response to changes in the client's condition? 8. Are clients and families informed of salient risk factors, as well as basic safety strategies? 9. Are all assessment findings documented and incorporated into the client's plan of care? 		

FALL-REDUCTION PROGRAM EVALUATION

RISK CONTROL ANALYSIS	YES/NO	CORRECTIVE ACTION
<p>STAFF EDUCATION</p> <ol style="list-style-type: none"> 1. Are educational in-service programs offered to direct care staff on a regular basis, and are attendance records kept? 2. Do staff educational programs focus on skills training, such as how to use gait belts and assist with transfers? 3. Do educational offerings examine the root causes of falls, as well as their prevention? 4. Are staff members instructed to assess and document the client’s condition at each visit, and also to: <ul style="list-style-type: none"> • Report any changes to the supervisor and family in a clear and timely manner? • Perform frequent home safety checks? • Reinforce fall-reduction tactics with clients and family? • Encourage clients to ask for assistance with risky tasks? • Keep accurate, detailed records of client encounters <p>POST-FALL ANALYSIS</p> <ol style="list-style-type: none"> 1. Are all clients fall reviewed for quality assurance purposes, including analysis of root causes and tracking of trends? 2. Does the post-fall analysis require caregivers to describe the circumstances of the fall, and also to: <ul style="list-style-type: none"> • Identify major causal factors, both personal and environmental? • Indicate the client’s functional status before and after the fall? • Suggest interventions to prevent or mitigate future falls? 3. Is the post-fall analysis thoroughly documented, and are findings incorporated into quality assurance and/or incident reporting programs 		

FALL RISK ASSESSMENT:

The fall risk assessment serves as the basis for care planning. The agency will conduct the fall risk assessment on each patient at start of care, when there is a change in patient's condition, and at re-certification.

Morse Fall Risk Assessment is an official fall risk assessment scales utilizes by Quality One Care Inc. (QOC).It is made up of six subscales:

1. History of falls
2. Secondary diagnosis
3. Ambulatory aid
4. IV or heparin lock
5. Gait
6. Mental status

**SEE ATTACHED MORSE FALL RISK ASSESSMENT/MORSE
FALL RISK ASSESSMENT TOOL**

EDUCATION:

In order to promote patient and family participation in the fall reduction and safety plan, the Fall Risk and Prevention procedure is introduced upon admission. Using the Morse Fall Scoring system. Besides admission, patients are reassessed based on change of status, transfer, or after a fall occurs.

The identified fall risk factors and interventions are reviewed with the patient and family. This is to help them understand why they are at risk for falls and increase their compliance with key interventions.

The goal of the agency is to assess and improve patients' knowledge of risks for fall, and how to prevent falls. The agency will use different teaching methods and tools that are appropriate to the patient/family level of understanding.

The education is documented and revised as patient status changes

Education Topics include the following

1. Impaired balance and gait
2. Vision
3. Medications
4. Environment
5. Chronic conditions

ENVIRONMENTAL ASSESSMENT

QOC understands that environmental assessment is effective in falls reduction. On initial assessment, the agency examines the physical environment to determine whether the home is safe for the patients. The agency will educate its nursing staff the importance of maintaining a safe environment for all its patients; assist with identifying patients who are high risk for fall; provide the tools to educate patient/families of the potential risk for falls and outline strategies to develop individualized plan of care to reduce fall. Often, some modifications are necessary to accommodate the functional abilities of the patients.

All patients are considered at risk of falling and simple prevention strategies have been put in place to ensure the risk of fall is minimized. A safe environment will be maintained for all patients. Standard safety measures have been put place for all patients regardless of identified risk, these include:

1. Patients are nursed in an appropriate bed
2. Orientate all patients and parents to room
3. Keep beds with brakes on
4. Side rails are raised for appropriate age and patient groups
5. Appropriate non slip footwear for ambulating patients
6. Maintain adequate lighting in child's room; low level lighting at night.
7. Keep floors clear of clutter including equipment and toys
8. Secure and supervise all children with a safety belt or harness in wheelchairs, highchairs, strollers, infant seats and any specialist seating)
9. Bathroom assist unsteady patients with ambulation
10. Place necessary items a patient may need within reach (drinking water, phone, etc)
11. Ensure equipment is well maintained and serviced appropriately (such as wheelchairs and commodes)

RECOMMENDATION

What can we do to prevent this from happening again? Care plan recommendations:

- High-Fall Risk Precautions
- Frequent monitoring
- Every 2hrs Toileting
- PT Evaluation
- Review of meds
- Clear path to Bathroom
- Remove clutter
- Non-slip footwear
- Hip protectors
- Improved positioning
- Other:
- Oxygen/IV tubing mgmt
- Patient/family education

Additional notes:

POST-FALL CHECKLIST

- √ **Notify physician**
- √ **Notify RN supervisor**
- √ **Assess patient for injury and document assessment findings in the nursing record**
- √ **Revise plan of care to include reduction strategies**
- √ **Filled out incident report**

POST-FALL ASSESSMENT

A post-fall assessment is a structured way to collect information after a fall. The patient will be carefully and systematically assessed for injuries. All findings will be documented in the nursing record, and an incident report will be filled.

The post-fall assessment focuses on immediate risk of injury or complications and will begin as soon as possible after the fall. It includes:

- . General information about the fall
- . Patient Assessment---vital signs; visible signs of injury (type & pain scores);
Glucometer (if diabetic); Glasgow Scale (if suspected brain injury and Morse Falls scale
- . Interventions based on Morse Falls scale
- . Notification of RN supervisor
- . Activation of EMS response team for emergency situation

The desired outcome of the post-fall assessment is to:

Specify root cause

Specify type of fall

Identify actions to prevent reoccurrence

Change plan of care

Involve patient/family in learning about the fall occurrence

Prevent repeat fall

PLAN OF CARE

POLICY

An individualized plan of care tailored to the client's risk factors will be developed by QOC. This is done after completion of the fall risk assessment and will be based on the assessment of the client's needs, strengths, limitations and goals.

PROCEDURE

The plan of care will match the identified client's risk factors such as mobility challenges, medication, mental status, and continence needs.

The plan of care identifies particular kinds of risks specific to a client and interventions to mitigate those risks.

The plan of care guides staff on how to reduce falls. Fall reduction care planning is a process by which the client's risk assessment information is translated into an action plan to address the client's needs. It is an active document that ensures continuity of care and changes as the client's condition changes.

The DON/RN (Director of Nursing, Registered Nurse) develops a Plan of Care for each client following completion of the risk assessment.

The individualized plan of care is developed for patients with any of the following:

- Patient has risk factors for falling (found on the risk assessment form)
- Patient has fallen since admission
- Patient or family are anxious about falls

Based on the results and the provisions of the Plan of Care, the DON will select the appropriate staff that meet the skills and experience qualification needed to provide the specific needs of the client. To maintain full compliance with the requirements of this policy, the following is addressed as applicable to each client:

- A. The client's plan of care is based on assessments of the client's health, function, and psychosocial condition.
- B. The assessment of a client is provided:
 - a. Before the client receives services from the agency
 - b. When there is a change in client's condition
 - c. At recertification
- C. The agency shall ensure that the care plan developed for the client at a minimum addresses:
 - (a) The services to be provided to the client, which are based on the assessment of the client
 - (b) When and how often the services are to provided
 - (c) How and by whom the services are to be provided
 - (d) Long-range and short-range goals for the client
 - (e) Physical needs, including safety measures to protect against fall and injury
- D. The client's plan of Care shall be reviewed by a registered nurse.

REVIEW OF MEDICATION

The agency reviews and evaluates medication-related fall risk on admission and at regular intervals. QOC has identified common ways medications contribute to falls. Such as:

- Sedation
- Impaired balance/coordination/reaction time
- Orthostatic hypotension
- Parkinsonism
- Cognitive changes

The agency has developed a screening tool to help identify the reactions of medication, and a medication related risk factors for fall (Table 1)

SCREENING MEDICATION FALL RISK

TABLE 1

Drug	Reaction
Ant diabetic agents	Hypoglycemia
Cardiovascular agents	Orthostatic hypotension, dizziness, syncope, bradycardia
Psychotropic agents	Psychomotor impairment, sedation, orthostatic hypotension, confusion
Analgesics	Sedation, Confusion
Metoclopramide	Psychomotor impairment, sedation
Anticonvulsants	Sedation, psychomotor impairment, confusion
Antihistamines	Sedation, confusion, blurred vision

The agency has also developed a Medication Fall Risk Scoring to determine if a patient is at risk for falls and plan care accordingly (Table 2)

MEDICATION FALL RISK SCORE

TABLE 2

Point value (Risk Level)	CLASS OF MEDICATION	REACTION
3 (High)	Analgesics, antipsychotics, anticonvulsants, benzodiazepines	Sedation, dizziness, postural disturbances, altered gait and balance, impaired cognition
2 (Medium)	Antihypertensive, cardiac drugs, antiarrhythmic, antidepressant,	Induced orthostatic, impaired Cerebral perfusion, poor health status
1 (Low)	Diuretics	Increased ambulation, induced orthostatic
Scores >= 6		Higher risk for fall; evaluate patient

To calculate the score, staff members have been taught add up the point value (risk level) for every medication the patient is taking. If the patient is taking more than one medication in a particular risk category, the score should be calculated by (risk level score) x (number of medications in that risk level category). For a patient at risk, the agency will use the evaluation tools to determine if medications may be tapered, discontinued, or changed to a safer alternative.

FALL REDUCTION PROGRAM EVALUATION

On evaluation, the interventions on the plan of care are noted to be effective and accurate. The agency licensed staff are providing adequate supervision and are committed to the reducing falls. Staff training on reduction of falls and identifying patients that are high risk for falls was noted to be effective.

Standard safety measures have been maintained.

The program appears to have had a protective effect. No fall or injury has been reported. Patient and patient family appears to be knowledgeable about the risk for fall and the prevention of falls.

STAFF TRAINING AND EDUCATION

The agency staff will be trained and educated on fall reduction and fall-related injuries. Reducing falls requires leadership commitment and a systematic approach.

The training/education will entail the following:

- A. Informing staff of the need to reduce falls/fall-related injuries by:
 - Communicating safety information to staff
 - Incorporating fall/safety precaution into the patient care
- B. Training staff on the standardized, validated tool used by the agency to identify risk factors for falls. (Morse Fall Scale is used by the agency)
- C. Training is provided to staff on using the tool to ensure inter-rater reliability.
- D. Informing staff of the interventions in the individualized plan of care based on identified fall and injury risks.
- E. Training on implementation of the interventions
- F. Training on assessment and continued reassessment of the patient
- G. Training on environmental safety
- H. Training on post-fall assessment and how to accurately fill the post-fall form

EXHIBIT 10

Staffing Plan & Staff Development Policy

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS
QOC Staffing Plan & Staff Development Policy
QOC Clinical Staffing & Competency Policy



QOC Staffing Plan & Staff Development Policy

I. PURPOSE

The purpose of this policy is to ensure that Quality One Care Home Health, Inc. (QOC) maintains sufficient, qualified, and competent staff to deliver safe, high-quality, and patient-centered home health services across all current and future service areas in Maryland. This policy establishes the framework for staffing, supervision, competency, recruitment, retention, training, and workforce development in alignment with patient needs, regulatory requirements, and organizational growth. QOC will adjust staffing levels as patient volume, acuity, and geographic scope increase, with phased staffing projections detailed separately in the agency's financial and statistical planning documents.

II. AGENCY-WIDE AND STATEWIDE SCOPE

QOC has operated across multiple Maryland jurisdictions since 2009 and anticipates continued expansion statewide. This Staffing Plan and Staff Development Policy applies to all QOC locations, counties, and future service areas. It ensures consistent quality, staffing standards, and regulatory compliance throughout the organization, including for high-acuity and pediatric patients. All staff, contractors, supervisors, and leaders are expected to adhere to this policy regardless of region.

III. STAFFING PHILOSOPHY

QOC believes that staffing directly impacts patient safety, clinical outcomes, satisfaction, and organizational performance. Therefore, staffing decisions are driven by:

- Patient acuity and clinical needs, not just volume.
- Use of the most qualified clinician for each task and service.
- Consistent caregiver assignments to ensure continuity of care.
- Appropriate staff-to-patient workloads to maintain quality.
- Competency-based role assignments.
- Strong clinical supervision and accountability.
- A supportive environment that attracts and retains top talent.
- Ethical, patient-first decision-making.
- Ongoing education and professional development.
- Anticipation of future growth and service expansion.

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

PH: 301 658-7141 / Fax: 301 658-2328

IV. REGULATORY COMPLIANCE

This policy ensures compliance with:

- CMS Conditions of Participation for Home Health Agencies (42 CFR 484.60 – Care Planning; 484.70 – HHA Services; 484.75 – Skilled Professional Services; 484.80 – Home Health Aide Services)
- COMAR 10.07.10 (Licensure of Home Health Agencies)
- COMAR 10.24.16 (State Health Plan – Access, Quality, Staffing, and Workforce)
- Joint Commission Human Resources (HR), Leadership (LD), and Provision of Care (PC) standards
- OSHA workplace safety requirements
- Federal and state labor and employment laws
- Professional licensure and scope of practice regulations

Compliance with these standards is mandatory and monitored continuously by leadership, QAPI, and the Governing Body.

V. STAFFING DETERMINANTS

QOC uses multiple factors to determine staffing needs:

- Number of active patients
- Number of admissions and discharges
- Patient acuity, complexity, and specialized needs
- Geographic distribution of patients
- Visit frequency and care intensity
- Service mix (skilled nursing, therapy, aide, social work)
- Regulatory supervision requirements
- Staff skill mix, licensure, and competency
- Productivity benchmarks
- Availability of qualified workforce in each region
- Seasonal trends and referral patterns
- Planned growth and program expansion
- Financial sustainability and operational capacity

Staffing levels are adjusted proactively as these factors change. Formal FTE projections and phased growth models are maintained separately as part of the agency's financial and statistical plans, including Certificate of Need submissions.



VI. ORGANIZATIONAL STRUCTURE AND KEY STAFF ROLES

QOC maintains a clear organizational structure to ensure oversight, supervision, and accountability.

Leadership and Management:

- **Governing Body:** Holds ultimate responsibility for staffing adequacy, quality, and patient safety.
- **Administrator/Executive Director:** Oversees operations, staffing resources, finances, and regulatory compliance.
- **Director of Nursing (DON)/Clinical Director:** Responsible for clinical staffing, competency, supervision, performance, and quality.
- **Clinical Supervisors/Team Managers:** Manage daily assignments, patient caseloads, and staff performance; conduct supervisory visits.
- **Discipline Leads (PT, OT, ST, MSW):** Provide discipline-specific oversight, training, and consultation.
- **Quality, QAPI, Patient Safety, and Compliance:** Monitor staffing effectiveness and identify opportunities for improvement.

Clinical Staff:

- **Registered Nurses (RN)** – perform assessments, develop care plans, provide skilled nursing, and supervise LPNs and HHAs.
- **Licensed Practical/Vocational Nurses (LPN/LVN)** – provide nursing care under RN supervision.
- **Physical Therapists (PT), Occupational Therapists (OT), Speech-Language Pathologists (ST)** – deliver specialized therapy services.
- **Medical Social Workers (MSW)** – provide psychosocial support, resource coordination, and counseling.
- **Home Health Aides (HHA)** – deliver personal care and ADL support under RN supervision.

Support Staff:

- Intake and Referral Coordinators
- Schedulers
- Administrative Support
- Quality and Compliance Staff
- Billing and Documentation Specialists

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As the agency expands, additional clinical supervisors, administrative personnel, and leadership positions will be added to support operations and maintain quality.

VII. STAFFING MODEL – INTERDISCIPLINARY, RN-LED TEAMS

QOC uses RN-led interdisciplinary teams to provide coordinated, patient-focused care. Each patient is assigned a primary RN case manager whenever possible. The primary RN coordinates services across disciplines, communicates with physicians, and ensures smooth transitions. Team members collaborate through case conferences, EMR communication, and shared care plans. High-acuity or pediatric cases may include specialty-trained clinicians and additional oversight.

This model supports:

- Comprehensive care planning
- Clinical accountability
- Interdisciplinary collaboration
- High-acuity care readiness
- Patient safety and quality outcomes
- Efficient resource use

VIII. CASELOAD AND PRODUCTIVITY STANDARDS

QOC sets realistic and safe productivity expectations based on best practices in home health.

Typical guidelines:

- RNs: 25–30 active patients or 5–6 visits/day (adjusted for acuity and travel)
- LPNs: 5–6 visits/day under RN supervision
- Therapists: 4–5 visits/day based on frequency and complexity
- MSW: 2–3 visits/day (due to assessment and resource coordination)
- HHAs: number of visits based on frequency in the care plan and geographic proximity

Caseloads are regularly adjusted based on:

- Patient acuity
- Number of skilled disciplines involved
- Geographic factors
- Travel time and rural distances
- Admission/discharge workload
- Staff experience and competency
- High-acuity or pediatric care demands

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Clinical supervisors review caseloads weekly to ensure safety and quality.

IX. DIRECT VS. INDIRECT STAFFING

QOC differentiates between:

- Direct caregivers: RN, LPN, PT, OT, ST, MSW, HHA
- Indirect/support staff: Supervisors, intake, scheduling, quality, compliance, administrative support, billing

This ensures that clinical staff can focus on patient care while support staff manage logistics, coordination, and documentation processes to maximize efficiency and quality.

X. CONTINUITY OF CARE

Consistent caregiver assignments are essential to quality outcomes, patient satisfaction, and trust. Therefore:

- Each patient is assigned a primary clinician.
- A minimum of three (3) backup caregivers are identified for each patient to ensure coverage.
- Backup staffing is included in the patient's care plan.
- Staff assignments consider geography, skills, language, and patient preference.
- Changes in assignment are communicated to the patient and documented.
- The RN Supervisor monitors continuity and resolves gaps or inconsistencies.

This approach comes directly from QOC's original policy and remains a core standard of care.

XI. SUPERVISION AND AUTHORITY

- All care is supervised by an RN or appropriate clinical discipline.
- The RN Supervisor or DON has the authority to reassign patients or staff at any time to ensure safety and efficiency.
- LPNs and HHAs always work under RN supervision.
- Supervisors conduct routine and as-needed field visits and chart audits.
- Performance evaluations include clinical quality, documentation, teamwork, compliance, and patient communication.
- Staff must practice within their scope of licensure and competency.
- Supervisors address performance issues promptly and support staff development.



XII. BACKUP AND EMERGENCY STAFFING

To ensure no interruption in patient care, QOC maintains multiple layers of backup:

- Three backup caregivers per patient (as required by original policy)
- Internal float staff or cross-trained staff
- PRN/per diem staff
- Overtime as needed
- Temporary staffing agencies (used sparingly and with oversight)
- Telehealth or remote check-ins when clinically appropriate
- On-call clinical staff available 24/7 for urgent needs
- Supervisor or DON may reassign staff in emergencies

This multi-level backup system ensures continuity of care regardless of staff illness, turnover, weather, or unexpected events.

XIII. STAFFING FOR HIGH-ACUITY AND SPECIALTY PATIENTS

QOC provides services for patients of all ages and levels of complexity, including high-acuity and pediatric populations. The agency maintains specialty-trained nurses and therapists who possess advanced competencies in tracheostomy and ventilator management, enteral and parenteral nutrition, complex wound care, infusion therapy, and chronic disease management. Pediatric clinicians are educated in growth, developmental monitoring, family teaching, and pediatric safety.

High-acuity and pediatric cases are assigned to staff whose competencies are validated and who receive ongoing education and supervision from the Director of Nursing or a qualified clinical lead. Staffing ratios for these cases are deliberately smaller to preserve patient safety and clinical effectiveness.

XIV. RECRUITMENT STRATEGY

QOC employs a structured, statewide recruitment program designed to attract, screen, and hire qualified personnel who share the agency's mission and values.

Key elements include:

- **Local recruitment** within each service county to support community employment and continuity.
- Partnerships with colleges, universities, and professional associations to build a pipeline of nursing and therapy graduates.
- Targeted outreach to experienced home health professionals and specialty nurses.

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- Competitive wages and benefits, flexible scheduling, and hybrid work options where appropriate.
- Credential verification and pre-employment competency review for all licensed and certified personnel.
- Recruitment based on projected service demand, patient acuity, and census trends derived from QOC's financial and statistical plans.

XV. RETENTION AND EMPLOYEE ENGAGEMENT

Retention is essential to quality and cost control. QOC promotes workforce stability by:

- Maintaining open communication between staff and leadership.
- Providing manageable caseloads and balanced productivity standards.
- Offering continuing education, certification support, and tuition assistance.
- Recognizing employee achievements through awards and evaluations.
- Encouraging career advancement through internal promotion and mentoring.
- Conducting annual staff satisfaction surveys and using results to guide improvement initiatives.
- Maintaining competitive compensation aligned with regional market data.

XVI. TRAINING AND COMPETENCY PROGRAM

QOC maintains a comprehensive training system in compliance with CMS, COMAR, and Joint Commission standards. All staff complete orientation and competency validation prior to patient contact, followed by annual re-evaluation.

Training includes:

- Home health regulations, documentation standards, and HIPAA compliance.
 - Infection control and emergency preparedness.
 - Patient rights, safety, and cultural competence.
 - High-acuity and pediatric specialty modules.
 - Clinical skills validation for each discipline.
 - Ongoing in-service education reflecting QAPI findings and emerging best practices.
- Training records are retained and audited by the Quality and Compliance Department. Competency gaps are corrected through individualized education or supervision plans.

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XVII. TECHNOLOGY AND TELEHEALTH SUPPORT

QOC leverages technology to enhance staffing efficiency and patient outcomes.

- A secure electronic health record (EHR) system supports scheduling, documentation, and quality tracking.
- Telehealth tools enable clinical follow-ups, monitoring, and supervision when permitted by payors.
- Mobile platforms allow field staff to access patient data in real time.
- Technology performance is reviewed quarterly to ensure reliability and privacy compliance.

XVIII. CONTINGENCY STAFFING AND EMERGENCY READINESS

To ensure uninterrupted services, QOC maintains contingency plans that include:

- PRN and on-call staff pools across all service areas.
 - Cross-trained personnel capable of filling multiple roles.
 - Cooperative agreements with reputable staffing vendors for emergency use.
 - Deployment of telehealth and supervisory check-ins during weather or disaster events.
 - A 24-hour on-call system supervised by clinical leadership.
- These procedures are integrated into the agency's Emergency Preparedness Plan.

XIX. STAFFING EFFECTIVENESS MONITORING

QOC continuously evaluates staffing effectiveness through quantitative and qualitative indicators such as:

- Patient outcomes and satisfaction.
 - Staff retention and turnover.
 - Overtime, missed-visit, and vacancy rates.
 - Referral acceptance and timeliness of admission.
 - Readmission and hospitalization rates.
- Findings are analyzed monthly by leadership and quarterly through the QAPI Committee and Governing Body. Corrective actions may include workload adjustments, targeted hiring, or process redesign. Trends are compared with state and national benchmarks.



XX. INTEGRATION WITH QAPI AND PATIENT SAFETY

Staffing data, performance indicators, and incident trends feed directly into QOC's Quality Assurance and Performance Improvement (QAPI) and Patient Safety Programs.

- Staffing-related concerns trigger performance improvement projects as appropriate.
- QAPI committees review data on caseload balance, staff competency, and patient satisfaction.
- Root-cause analysis is conducted for any adverse events linked to staffing or supervision.
- Results are communicated to staff, and education or process changes are implemented.

XXI. LEADERSHIP AND GOVERNING BODY ACCOUNTABILITY

The Administrator and Director of Nursing are responsible for ensuring adequate staffing at all times, supported by Human Resources, Quality, and Finance. They submit quarterly reports on staffing adequacy, turnover, and quality outcomes to the Governing Body.

The Governing Body reviews these reports, approves major staffing changes, and verifies that the agency has the human and financial resources to meet patient needs across all jurisdictions. Leadership accountability for staffing is tied to performance evaluation and strategic planning.

XXII. ANNUAL STAFFING PLAN REVIEW AND UPDATE

This policy is reviewed annually and revised as needed to reflect:

- Changes in patient census or acuity.
 - Geographic expansion or new service lines.
 - Workforce availability and market trends.
 - QAPI and compliance findings.
 - Updates to regulatory or accreditation standards.
- Adjustments are approved by the Administrator, Director of Nursing, and Governing Body and documented in the annual strategic and financial plans.

XXIII. CONCLUSION

This Staffing Plan and Staff Development Policy establishes QOC's statewide framework for maintaining a qualified, competent, and compassionate workforce. It ensures that staffing decisions are data-driven, responsive to patient needs, and consistent with regulatory and accreditation standards. QOC's leadership remains committed to continuous improvement, workforce sustainability, and the delivery of safe, high-quality, patient-centered care across all Maryland jurisdictions.

EXHIBIT 11

Core Policies

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS

Scope of Services & Service Delivery Model

Care Transitions & referral Coordination Policy

Patient Safety Program Policy

Incident Reporting Policy

Documentation & Record Keeping Policy

Data Collection & Submission Policy

Admission & Discharge Policy



QOC Scope of Services & Service Delivery Model Policy

I. Purpose

The purpose of this policy is to define the full scope of home health services offered by Quality One Care Home Health, Inc. (QOC) and to describe the structured, patient-centered model by which these services are delivered, coordinated, and monitored. This policy ensures that all care provided by QOC is safe, evidence-based, high-quality, and compliant with applicable laws, regulations, and clinical standards.

II. Regulatory Compliance

This policy ensures compliance with:

- CMS Conditions of Participation for Home Health Agencies (42 CFR Part 484)
- COMAR 10.24.16 – Home Health Agency Standards
- COMAR 10.07.10 – State Licensing Regulations for HHAs
- Maryland State Health Plan (access, quality, continuity)
- Joint Commission Home Care Accreditation Standards
- Medicare Conditions of Participation (Plan of Care, Skilled Services, Coordination of Care, OASIS)
- HIPAA and OSHA standards

III. Philosophy of Care

QOC operates according to the following principles:

- **Patient-centered:** Care is individualized based on the patient's needs, goals, and preferences.
- **Physician-directed:** All skilled services are provided under a physician-ordered plan of care.
- **Interdisciplinary:** Care is delivered by a coordinated team of nurses, therapists, social workers, and aides.
- **Evidence-based:** Services follow clinical guidelines and best practices.
- **Outcome-driven:** Success is measured by improvement, safety, satisfaction, and quality of life.
- **High-acuity capable:** QOC is equipped to manage complex, medically fragile, and pediatric patients.
- **Culturally competent and equitable:** QOC serves all patients with respect and removes barriers to care.

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- **Continuous improvement:** Quality is supported by QAPI, data monitoring, and performance evaluation.

IV. Scope of Services Provided

QOC delivers the **full continuum of Medicare-certified home health services**, including but not limited to:

1. Skilled Nursing (RN/LPN)

- Comprehensive assessments (OASIS, head-to-toe, functional, psychosocial)
- Medication management & reconciliation
- IV therapy (antibiotics, hydration, TPN)
- Enteral feeding & tube management
- Tracheostomy/ventilator care
- Wound care (including complex, negative pressure, post-surgical)
- Chronic disease management (CHF, COPD, diabetes, dementia, hypertension)
- Foley catheter care
- Pain management
- Vital signs and symptom monitoring
- Patient and caregiver education
- Telehealth-supported monitoring (when appropriate)
- 24/7 RN on-call support

2. Therapy Services

Physical Therapy (PT):

- Mobility and strength training
- Gait training & balance
- Post-surgical rehab
- Fall prevention programs
- Pain management strategies
- Home safety assessments

Occupational Therapy (OT):

- Activities of Daily Living (ADLs)
- Fine motor and cognitive skills
- Adaptive equipment training
- Energy conservation techniques
- Environmental modifications

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Speech Therapy (ST):

- Speech and language rehabilitation
- Swallowing evaluations and therapy
- Cognitive-communication training
- Voice therapy

3. Medical Social Work (MSW)

- Psychosocial assessments
- Counseling and emotional support
- Advance care planning and goals of care
- Resource coordination (housing, food, transportation)
- Long-term care planning
- Crisis intervention
- Support for family/caregivers

4. Home Health Aide (HHA) / Personal Care

- Personal hygiene (bathing, grooming, dressing)
- Mobility and transfer assistance
- Vital signs under RN supervision
- Exercise assistance
- Light homemaking and meal prep (as permitted)
- Skin care and prevention of pressure ulcers
- Observation and reporting of condition changes

All aide services are **supervised by an RN or therapist** per CMS requirements.

5. High-Acuity Specialty Programs (QOC Strength)

QOC specializes in complex, medically fragile patients:

- Ventilator and tracheostomy care
- Complex wound care (stage 3/4, negative pressure therapy)
- Enteral and parenteral nutrition
- IV infusion therapy
- Neurologic conditions (stroke, TBI, SCI)
- Respiratory failure
- Oncology/home chemo coordination (if ordered)
- Sepsis recovery management

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6. Pediatric Home Health Services

- Skilled pediatric nursing (RN/LPN)
- Tracheostomy/vent care in children
- Seizure monitoring and neuro care
- Congenital condition management
- Chronic illness management (e.g., muscular dystrophy, diabetes)
- Developmental milestone support (with therapy)
- Caregiver training and support
- School coordination (as appropriate)
- Emotional and psychosocial support for families

QOC hires or trains clinicians with **pediatric-specific expertise**.

7. Chronic Disease Management Programs

QOC offers structured, evidence-based programs for:

- **Congestive Heart Failure (CHF)**
- **Chronic Obstructive Pulmonary Disease (COPD)**
- **Diabetes**
- **Hypertension**
- **Dementia / Alzheimer's**
- **Parkinson's Disease**
- **Post-COVID recovery**
- **Post-surgical transitions**
- **Palliative care coordination (non-hospice)**

Each program includes:

- Symptom monitoring
- Red-flag education
- Self-management support
- Medication adherence
- Dietary counseling
- Telehealth as appropriate
- Readmission prevention strategies



8. Additional Services / Capabilities

- Medication blister packing coordination
- Dietitian services (if available)
- Remote monitoring and telehealth
- Caregiver training and competency checks
- Transitional care and post-hospital support
- Behavioral health referrals
- Case management
- Palliative/hospice care coordination
- Community resource linkage

V. Service Delivery Model

QOC follows a **structured, interdisciplinary, patient-centered model** of service delivery:

1. Referral & Intake

- Referrals accepted from hospitals, physicians, payors, community, and self-referrals
- Eligibility and insurance verified
- Clinical appropriateness assessed
- High-acuity needs flagged
- Start of Care scheduled promptly (within 48h or sooner)

2. Initial Assessment

- Performed by RN or qualified therapist (OASIS when required)
- Comprehensive assessment of medical, functional, psychosocial, and safety needs
- Identification of risks (falls, readmission, infection, high-acuity)
- Education and goal-setting with patient/family

3. Plan of Care (POC)

- Developed with patient/caregiver input
- Ordered and signed by physician
- Includes frequency, duration, interventions, goals, and target outcomes
- Updated at least every 60 days or as needed

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4. Interdisciplinary Care

- Each discipline follows the POC
- Coordination via case conferences, EMR, and real-time communication
- RN Case Manager leads coordination for high-acuity or complex patients

5. Visit Frequency

Determined by:

- Physician order
- Clinical need and acuity
- Evidence-based protocols
- Regulatory requirements
- Patient/caregiver capacity

Visits may be increased for instability or reduced as goals are met.

6. High-Acuity Management

- More frequent monitoring
- Specialized staff (trained RN/LPN)
- Technology support (telehealth, remote monitoring)
- 24/7 on-call support
- Escalation plan if condition worsens

7. Telehealth Integration

Telehealth may be used to:

- Supplement in-person care
- Monitor vitals and symptoms
- Provide education and follow-up
- Improve access in rural areas

Telehealth does not replace required in-person visits unless permitted by CMS/payer.

8. Caregiver & Patient Education

- Disease and symptom management
- Medication safety
- Equipment and device training
- Emergency contact and escalation
- Preventive strategies (falls, infection)

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- Self-care and independence promotion

9. Coordination with External Providers

- Regular communication with physicians
- Collaboration with hospitals (post-discharge planning)
- Referrals to specialists or community services
- Coordination with DME, pharmacy, and MSW for support
- Warm handoffs when transitioning to other care levels

10. Discharge Planning

Begins at admission and includes:

- Achievement of goals
- Transition to self-care or caregiver support
- Referral to other providers (SNF, outpatient, hospice)
- Notification to physician
- Written discharge summary (within 5 business days)
- Follow-up call to ensure smooth transition

VI. Quality, Safety, And Continuity

QOC ensures high-quality service delivery through:

- Competency-based staffing
- Clinical supervision and case management
- Routine chart audits and documentation reviews
- QAPI program (data-driven improvement)
- Patient satisfaction surveys (QOC 98%+ historically)
- Monitoring of key performance indicators (readmissions, falls, infection, timeliness, outcomes)
- Emergency preparedness integration
- Health equity and access tracking
- Technology and data analytics to optimize care

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VII. Limitations and Exclusions

QOC does **not** provide:

- 24-hour in-home private duty care
- Non-medical transportation
- Long-term custodial care without skilled component
- Services outside clinical scope or licensure
- Experimental or non-evidence-based treatments

If a service cannot be provided:

- QOC will inform the patient and referral source
- Provide alternative provider options
- Assist in safe transfer when needed

VIII. Review & Approval

This policy will be:

- Reviewed at least annually
- Updated based on regulatory changes, QAPI findings, clinical best practices, or service expansion
- Approved by the Administrator / Governing Body
- Communicated to all staff upon revision



QOC Care Transition & Referral Coordination Policy

I. Purpose

The purpose of this policy is to ensure smooth, safe, timely, and well-coordinated transitions of care for all patients referred to or discharged from Quality One Care Home Health, Inc. (QOC). This policy establishes a structured, patient-centered process for accepting referrals, coordinating with hospitals and community providers, initiating care promptly, preventing fragmentation, and ensuring continuity of services across all settings of care.

II. Philosophy

QOC believes that effective care coordination:

- Improves patient outcomes and safety
- Reduces avoidable hospital readmissions
- Enhances patient and caregiver satisfaction
- Supports health equity and access
- Strengthens relationships with hospitals and providers
- Ensures continuity of care across the healthcare continuum

III. Regulatory Compliance

This policy aligns with:

- CMS Conditions of Participation (42 CFR 484.60 – Care Planning and Coordination, and 484.50 – Patient Rights)
- COMAR 10.07.10 & 10.24.16 (Continuity of Care, Discharge, Quality Standards)
- Joint Commission Standards (Transitions of Care, Coordination of Services)
- Maryland Total Cost of Care Model (reducing avoidable utilization)

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IV. SCOPE

This policy applies to:

- All referrals (hospital, physician, facility, community, self)
- All clinical disciplines (RN, LPN, PT, OT, ST, MSW, HHA)
- All patients (adult, pediatric, high-acuity, medically complex)
- All staff involved in intake, scheduling, clinical coordination, documentation, and discharge

V. Transitions Into Qoc (Referral Intake Process)

A. Referral Sources

QOC accepts referrals from:

- Hospitals and hospital discharge planners
- Physicians and specialists
- Skilled nursing facilities (SNFs) and rehab centers
- Assisted living / group homes
- Community agencies and case managers
- Insurance/payor care managers
- Self-referral / family / caregiver

B. Referral Information Requirements

Referrals should include:

- Patient demographics and contact information
- Diagnosis and medical history
- Current clinical status / acuity level
- Medication list
- Physician orders
- Required disciplines (RN, PT, OT, etc.)
- Equipment/supply needs (DME, oxygen)
- Insurance/payor information
- Discharge instructions and goals of care

C. Rapid Response Standards

To ensure timely access:

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- QOC reviews all referrals **immediately upon receipt**
- All referrals are acknowledged **within 2 hours (business hours)**
- Eligibility, capacity, and clinical appropriateness are verified
- Start of Care (SOC) is initiated:
 - **Within 48 hours of referral OR**
 - **Within 48 hours of patient discharge OR**
 - **On the physician-specified date**
 - **Same-day or next-day start** for high-acuity/hospital discharge patients when requested

D. Acceptance Criteria

QOC accepts patients when:

- Ordered services are within scope of practice
- Care can be provided safely in the home
- QOC has capacity and appropriate staff
- Required payer authorization is obtained
- Patient or representative consents to care

E. If QOC Cannot Accept Patient

QOC will:

- Notify the referral source immediately with reason
- Provide alternate provider options if available
- Document reason for non-admission
- Report trends to QAPI for capacity planning

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VI. Transition from Hospital/Facility to Home (Start Of Care)

A. Pre-Discharge Coordination

QOC coordinates with hospital discharge planners, providers, and caregivers to:

- Confirm readiness for discharge
- Obtain clinical information and orders
- Ensure medication reconciliation
- Arrange DME (oxygen, wound vac, ventilator, enteral pump, etc.)
- Clarify caregiver support and home environment
- Identify high-risk or high-acuity needs
- Confirm preferred start-of-care date/time

B. Physician Communication

- Obtain signed plan of care (485)
- Clarify orders and goals
- Notify physician of any concerns, barriers, or delays
- Maintain ongoing updates on patient progress, changes in condition, or readmission

C. Start of Care (SOC) Visit

- Initial SOC assessment performed by RN or qualified therapist (per CMS)
- OASIS completed (if required)
- Medication reconciliation performed
- Emergency preparedness and safety needs assessed
- Plan of care developed and discussed with patient/family
- Follow-up visits scheduled



VII. Internal Handoff & Interdisciplinary Coordination

Successful transitions require teamwork. QOC ensures:

- Intake hands off complete referral data to clinical manager
- Clinical manager assigns appropriate staff based on acuity and geography
- Interdisciplinary team communicates through:
 - Case conferences
 - EMR documentation
 - Phone calls or secure messaging
 - High-risk patient alerts/flags
- Each discipline follows the same plan of care and goals

For high-acuity or complex cases, the clinical manager or RN case manager leads coordination.

VIII. Reducing Hospital Readmissions

QOC actively works to prevent avoidable readmissions by:

- Rapid post-discharge admission (24-48h or sooner)
- Close monitoring of high-risk diagnoses (CHF, COPD, diabetes, wounds, sepsis, fall risk)
- Clinical pathways and evidence-based protocols
- Patient/caregiver education on warning signs
- 24/7 on-call nurse availability
- Immediate physician notification of changes in condition
- Telehealth or extra visits as needed
- Caregiver empowerment and support
- Coordination with physicians and hospitals for early intervention

Readmission data is monitored through QAPI.

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IX. Care Transition Out of Qoc (Transfer or Discharge)

Patients may transition to:

- Hospital or ED
- SNF/Rehab
- Hospice or palliative care agency
- Another home health agency
- Assisted living facility
- Self-care or caregiver-only support

QOC will:

- Notify patient and physician in advance
- Clarify reason for transfer/discharge
- Submit required discharge notice (including NOMNC for Medicare)
- Provide verbal and written handoff to next provider
- Transfer medical records securely
- Ensure first visit or admission by receiving agency (when possible)
- Provide discharge summary within **5 business days** of discharge or transfer
- Avoid inappropriate or retaliatory discharges

X. Patient & Family Education During Transitions

QOC ensures patients and caregivers understand:

- What to expect from home health
- Visit schedule and disciplines involved
- Medications and equipment
- Signs/symptoms requiring help
- How to reach QOC 24/7
- Emergency instructions (when to call 911)
- Follow-up appointments
- How to request additional services or report concerns

Education is documented in the medical record.



XI. Documentation Standards

QOC documents:

- Referral details and timeliness
- Start-of-care assessments and orders
- Communication with physician/referral source
- Equipment and supply setup
- Transition barriers and resolution
- Internal coordination notes
- Transfer or discharge summary (within 5 days)
- Readmission or adverse events related to transitions
- Patient and caregiver education
- Follow-up actions and outcomes

XII. Quality Monitoring & Qapi Integration

QOC monitors:

- Referral response times
- Start-of-care timeliness
- % of high-acuity or hospital discharge patients admitted within 24-48h
- Readmission rates (30-day)
- Emergency department utilization
- Reasons for missed visits or delayed admissions
- Reasons for transfer or discharge
- Patient satisfaction with transitions
- Referral source feedback
- Breakdown points in coordination

These metrics are reviewed by the **QAPI Committee** and used to develop **Performance Improvement Projects (PIPs)** to continuously improve care coordination and outcomes.

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XIII. Collaboration with Referral Sources & Community Partners

QOC maintains strong relationships with:

- Hospitals and discharge planners
- Physicians and specialists
- Accountable Care Organizations (ACOs)
- Managed care and value-based networks
- SNFs, rehab, ALFs, group homes
- Community case management and aging services
- DME and pharmacy providers

QOC participates in:

- Hospital/post-acute care meetings
- Readmission reduction initiatives
- Community health coalitions
- Care transition collaboratives
- Emergency preparedness coalitions

XIV. Policy Review & Approval

This policy is:

- Reviewed annually
- Updated based on QAPI findings, regulatory changes, and best practices
- Approved by the Administrator
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QOC participates in:

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- Community health coalitions
- Care transition collaboratives
- Emergency preparedness coalitions

XIV. Policy Review & Approval

This policy is:

- Reviewed annually
- Updated based on QAPI findings, regulatory changes, and best practices
- Approved by the Administrator
- Communicated to all staff



QOC Patient Safety Program and Policy

I. PURPOSE

The purpose of this Patient Safety Program & Policy is to establish a comprehensive, organization-wide system to identify, prevent, and reduce patient harm; promote a strong culture of safety; ensure compliance with all federal and state regulations; and continuously improve the quality and safety of patient care. This program ensures that patient safety is integrated into every aspect of QOC's clinical and administrative operations, including high-acuity and pediatric care.

II. PHILOSOPHY

Quality One Care Home Health, Inc. believes:

- Every patient has the right to receive safe, high-quality care.
- Patient safety is the foundation of clinical excellence.
- Preventing errors is more effective than reacting to them.
- Safety requires transparency, accountability, and open communication.
- Staff must feel empowered to report concerns without fear.
- Learning from near misses is as valuable as learning from adverse events.
- High-acuity and medically fragile patients require enhanced safety oversight.
- Patient and family engagement improves safety outcomes.
- Safety is **everyone's responsibility**, from leadership to frontline staff.

III. REGULATORY COMPLIANCE

This Patient Safety Program complies with:

- CMS Conditions of Participation for HHAs (42 CFR §484.60, §484.65, §484.70)
- COMAR 10.07.10 (Licensure, Patient Safety, Incident Reporting)
- COMAR 10.24.16 (State Health Plan for HHAs – Quality & Patient Protection)
- Joint Commission National Patient Safety Goals and Sentinel Event Policy
- Maryland State Reporting Requirements
- HIPAA Privacy & Security Rules
- OSHA and CDC safety standards
- Federal and state abuse/neglect laws



IV. SCOPE

This program applies to:

- All QOC staff, contractors, PRN, volunteers, and leadership.
- All clinical disciplines (RN, LPN, PT, OT, ST, MSW, HHA).
- All patients, regardless of age, diagnosis, acuity, or payer.
- All geographic regions and care settings (home, community, telehealth).
- All operational and clinical processes.
- All incidents, near misses, adverse events, and sentinel events.

V. PATIENT SAFETY PROGRAM GOALS

1. **Identify** risks, hazards, and unsafe conditions.
2. **Prevent** errors and adverse events before they occur.
3. **Reduce** harm through rapid response and mitigation.
4. **Investigate** incidents using Root Cause Analysis (RCA).
5. **Improve** systems and processes using data-driven solutions.
6. **Engage** patients, families, and caregivers in safety.
7. **Educate** staff in best practices and competency.
8. **Support** staff involvement and psychological safety.
9. **Coordinate** safety efforts with Quality, Compliance, Risk, and Infection Control.
10. **Evaluate** effectiveness through QAPI and annual review.

VI. LEADERSHIP RESPONSIBILITY AND ACCOUNTABILITY

A. Governing Body

The Governing Body holds ultimate responsibility for patient safety. It shall:

- Establish and support a culture of safety.
- Approve the Patient Safety Program.
- Receive and review quarterly safety reports.
- Ensure appropriate resources (staffing, training, equipment).
- Monitor performance and hold leadership accountable.
- Approve corrective action plans and systemic improvements.

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B. Administrator/Executive Director

Responsible for:

- Operational integration of patient safety.
- Ensuring staff have time, tools, and training to prioritize safety.
- Supporting non-punitive reporting and transparency.
- Collaborating with the Director of Nursing and Patient Safety Officer.

C. Director of Nursing (Clinical Director)

Responsible for:

- Clinical safety oversight.
- Implementation of evidence-based safety practices.
- Ensuring competency and supervision of clinical staff.
- Leading Root Cause Analyses and corrective actions.
- Monitoring high-risk and high-acuity cases.

D. Patient Safety Officer (PSO)

(QOC may designate the DON or appoint a separate PSO)

Responsible for:

- Coordinating the Patient Safety Program.
- Collecting and analyzing safety data.
- Leading or coordinating investigations (RCA, HFMEA).
- Reviewing incident trends and system vulnerabilities.
- Reporting findings to Leadership, QAPI, and Governing Body.
- Serving as a safety resource to staff.

VII. PATIENT SAFETY TEAM / COMMITTEE

QOC maintains an interdisciplinary **Patient Safety Team**, either as a standalone group or as a formal component of the **QAPI Committee**.

Members may include:

- Patient Safety Officer (Chair)
- Director of Nursing
- Quality/QAPI Coordinator

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- Clinical Supervisors
- Field RN and Therapist representatives
- Home Health Aide Supervisor
- Risk Management/Compliance
- Infection Control representative
- Other disciplines as needed (MSW, Pediatrics, High-Acuity specialist)

Responsibilities:

- Review incidents, near misses, and patterns.
- Conduct Root Cause Analyses and recommend improvements.
- Perform proactive risk assessments (including HFMEA).
- Monitor high-risk/high-volume/problem-prone processes.
- Evaluate patient safety initiatives and outcomes.
- Recommend policy or process changes.
- Coordinate safety-related training.
- Report outcomes to Administrator and Governing Body.

VIII. CULTURE OF SAFETY & NON-PUNITIVE REPORTING

QOC fosters a culture where:

- **Safety is a core value, not a task.**
- Staff are encouraged to “STOP and SPEAK UP.”
- Reporting safety concerns is EXPECTED and VALUED.
- Staff will not be penalized or retaliated against for reporting incidents, near misses, or unsafe conditions.
- Errors are analyzed to improve systems, not to assign blame.
- Just Culture principles are applied — focusing on system design and personal accountability.
- Leadership models transparency and open communication.

Anonymous or confidential reporting options are available.



IX. INTEGRATION WITH OTHER PROGRAMS

Patient Safety is fully integrated with:

- **QAPI Program (Quality Assessment & Performance Improvement)**
- **Risk Management**
- **Infection Prevention & Control**
- **Incident Reporting System**
- **Emergency Preparedness & Disaster Response**
- **Clinical Policies and Procedures**
- **Staff Education & Competency Program**
- **Performance Improvement Projects (PIPs)**

Safety events, trends, and solutions are shared across these programs to promote continuous improvement.

X. CORE PATIENT SAFETY PROCESSES

QOC focuses on the following high-risk, high-volume, or problem-prone areas to proactively prevent harm:

1. Fall Prevention

- Fall risk assessments at SOC and ongoing
- Home safety/environmental checks
- Assistive devices and mobility support
- Patient/caregiver education
- Fall incident review and corrective action

2. Medication Safety

- Medication reconciliation at admission, recertification, and with changes
- Review of drug interactions and duplications
- Safe administration techniques
- Education on purpose, dosage, side effects
- Communication with physician and pharmacy
- Monitoring for adherence and adverse reactions



3. Infection Prevention & Control

- Standard and transmission-based precautions
- Hand hygiene compliance
- Wound care protocols
- Management of multi-drug-resistant organisms (MDROs)
- Surveillance of infections
- Staff/patient vaccination support
- Reporting of outbreaks to health authorities

4. High-Acuity Patient Management

- Ventilator/tracheostomy care protocols
- Emergency equipment verification
- Backup power planning
- Specialized staff assignments
- Collaboration with respiratory therapists and physicians
- 24/7 RN availability

5. Pediatric Patient Safety

- Age-specific assessment and treatment
- Pediatric medication dosing verification
- Caregiver training and competency checks
- Developmental and psychosocial support
- Coordination with pediatric specialists

6. Pressure Injury Prevention

- Risk assessment (e.g., Braden Scale)
- Repositioning and offloading
- Nutrition and hydration support
- Early wound care interventions
- Monitoring and documentation

7. Abuse, Neglect, and Exploitation Prevention

- Staff screening and background checks
- Mandatory reporting to authorities
- Immediate action and protection protocols
- Zero-tolerance policy
- Root Cause Analysis and corrective measures



XI. REPORTING OF SAFETY EVENTS

A. What Must Be Reported

- Incidents (falls, injuries, med errors, equipment failure, infection, emergency care)
- Near misses (potential harm avoided)
- Adverse events (unexpected harm)
- Sentinel events (death or serious harm not related to natural disease)
- Patient/staff safety concerns or hazards
- Alleged abuse/neglect or exploitation
- Unsafe home environments

B. How to Report

- Immediately to supervisor or Patient Safety Officer (verbal)
- Complete written Incident Report within 24 hours
- Document relevant details in the patient's medical record as appropriate

C. Non-Retaliation

No staff member will be punished or retaliated against for reporting an event or concern in good faith.

XII. INVESTIGATION & ROOT CAUSE ANALYSIS (RCA)

A. When RCA is Required

- Sentinel events (death or serious harm)
- Recurrent or pattern events
- High-risk system failures
- Mandated events (per regulatory bodies)
- At leadership or Safety Committee discretion

B. RCA Process

1. Assemble interdisciplinary team
2. Gather facts and timeline
3. Identify contributing factors
4. Determine root/system causes



5. Develop corrective action plan
6. Implement interventions
7. Monitor for sustained improvement
8. Report findings to Governing Body / QAPI

RCA focuses on system improvement, not individual blame.

XIII. PROACTIVE RISK ASSESSMENT (HFMEA)

Each year, QOC selects at least **one high-risk, high-volume, or problem-prone process** and performs a **Healthcare Failure Mode and Effects Analysis (HFMEA)** to proactively identify vulnerabilities.

Examples:

- Hospital-to-home transitions
- High-acuity patient onboarding (e.g., ventilator, IV therapy)
- Medication management for polypharmacy
- Pediatric complex care
- Fall prevention workflows

Results are used to redesign systems, improve processes, and prevent harm.

XIV. CORRECTIVE ACTIONS & SYSTEM IMPROVEMENT

Corrective actions may include:

- Policy or procedure changes
- Creation of checklists or protocols
- Staff training or competency validation
- Process redesign
- Technology or documentation improvements
- Increased monitoring or supervision
- Additional resources or equipment
- Collaboration with external providers

All corrective actions are **tracked until sustained and effective.**



XV. FULL DISCLOSURE OF SERIOUS EVENTS

QOC follows **ethical transparency** in patient care:

- Patients and families will be informed of unanticipated outcomes, serious incidents, or errors affecting their care.
- Disclosure includes clear explanation, next steps, and support.
- Regulatory bodies are notified as required by law or accreditation.
- Documentation of disclosure is maintained.

XVI. STAFF SUPPORT & SECOND VICTIM CARE

QOC recognizes that staff may experience emotional distress after serious safety events.

QOC provides:

- Private debriefing
- Counseling or Employee Assistance Program (EAP) referrals
- Peer support
- Non-punitive debriefing to support learning and recovery

Healthy staff = safer patients.

XVII. TRAINING & COMPETENCY

All staff receive:

- Patient safety orientation at hire
- Annual safety education
- Education on incident reporting and just culture
- Discipline-specific competency validation
- High-acuity and pediatric safety training (as applicable)
- Annual updates from QAPI and Patient Safety Committee findings
- Drills for emergency response and communication



XVIII. DATA MONITORING & PERFORMANCE MEASURES

QOC tracks and analyzes:

- Incident rates and types
- Near misses and trends
- Sentinel events and outcomes
- 30-day hospital readmissions
- Falls and injuries
- Medication errors
- Infection rates
- Patient complaints/grievances
- Missed or delayed visits related to safety
- Staff safety reports
- Patient satisfaction and perception of safety

These metrics are reviewed by the Patient Safety Committee and QAPI.

XIX. LEADERSHIP EVALUATION & ACCOUNTABILITY

Leadership is evaluated based on:

- Support of patient safety initiatives
- Implementation of safe practices
- Response to identified risks or trends
- Timeliness of corrective actions
- Use of evidence-based safety strategies
- Engagement in QAPI and patient safety meetings
- Safety outcomes and performance indicators

Performance on safety directly influences leadership evaluations and decision-making.



XX. INTEGRATION WITH QAPI

Every safety event is an opportunity to improve. Patient safety data feeds directly into the **QAPI Program** to:

- Identify Performance Improvement Projects (PIPs)
- Set measurable goals
- Monitor and track safety outcomes
- Ensure sustainability of improvements
- Share lessons learned with staff

XXI. ANNUAL EVALUATION OF PATIENT SAFETY PROGRAM

Once per year, QOC completes a formal evaluation of the Patient Safety Program, including:

- Analysis of safety data and trends
- Review of incidents, near misses, and sentinel events
- RCA and HFMEA outcomes
- Evaluation of corrective actions and system changes
- Assessment of staff training effectiveness
- Survey of safety culture
- Identification of high-risk areas for next year
- Recommendations for resource allocation
- Governing Body review and approval

XXII. DOCUMENTATION & RECORDKEEPING

QOC maintains documentation of:

- Incident reports and investigations
- Root Cause Analyses and HFMEA results
- Corrective action plans and follow-up
- Patient/family disclosures (when applicable)
- Safety Committee and QAPI meeting minutes
- Staff safety training and competencies
- Annual program evaluations
- Reports to external agencies (when required)

Documentation is secure, confidential, and retained per regulatory requirements.

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XXIII. POLICY REVIEW & APPROVAL

This policy is:

- Reviewed at least **annually**
- Updated based on findings, regulations, best practices, or organizational changes
- Approved by the **Administrator / Governing Body**
- Communicated to all staff upon revision



INCIDENT REPORTING POLICY AND PROCEDURE

I. PURPOSE

The purpose of this policy is to ensure that all incidents, near misses, adverse events, staff injuries, safety concerns, and other reportable events are promptly identified, reported, investigated, and resolved in order to protect patients, staff, and the organization. This policy promotes a culture of safety, transparency, accountability, and continuous improvement. Timely incident reporting helps prevent harm, reduces risk, and ensures compliance with regulatory requirements.

II. PHILOSOPHY

QOC is committed to a non-punitive environment where staff are encouraged and expected to report all incidents and concerns without fear of retaliation. Incidents are not viewed as failures by individuals, but as opportunities to improve systems and processes. Every employee shares responsibility for patient safety and risk prevention. High-acuity and pediatric patients require heightened safety monitoring, and all incidents involving vulnerable populations receive immediate attention.

III. REGULATORY COMPLIANCE

This policy complies with the following:

- CMS Conditions of Participation (42 CFR §484.60, §484.65, §484.70)
- COMAR 10.07.10 (Licensure and Patient Safety Requirements)
- COMAR 10.24.16 (State Health Plan – Quality and Patient Protection)
- Joint Commission standards for patient safety and sentinel event reporting
- Maryland mandatory reporting laws for abuse, neglect, exploitation, and serious injury
- OSHA requirements for employee injury reporting and workplace safety
- HIPAA Privacy and Security Rules for documentation and confidentiality

IV. SCOPE

This policy applies to:

- All QOC employees, contractors, volunteers, and students
- All care settings (patient homes, community settings, telehealth visits)
- All patients, family members, caregivers, and visitors
- All disciplines (RN, LPN, PT, OT, ST, MSW, HHA, administrative staff)
- All incidents involving patient care, safety, documentation, equipment, privacy, or staff injury



V. DEFINITIONS

Incident: Any unexpected or unplanned event that has the potential to or does result in harm, injury, or jeopardy to a patient, staff member, or visitor.

Adverse Event: An incident that caused actual harm or injury.

Sentinel Event: A serious, unexpected event that results in death, permanent harm, severe temporary harm, or poses a significant risk of such outcomes. These events require immediate leadership review and Root Cause Analysis.

Near Miss: An event that could have caused harm but did not, either by chance or timely intervention. Near misses must be reported, as they reveal safety vulnerabilities.

Unsafe Condition: A circumstance where a hazard exists that could potentially cause an incident. Staff are expected to report unsafe conditions even if no incident occurred.

High-Risk Incident: Any event involving high-acuity patients, medication errors, infection, falls with injury, equipment failure, or pediatric patients.

VI. CULTURE OF SAFETY AND NON-PUNITIVE REPORTING

QOC maintains a Just Culture that encourages incident reporting without fear of punishment. Staff will not be blamed or disciplined for reporting incidents, near misses, or unsafe conditions. However, deliberate misconduct, willful neglect, or illegal actions may result in disciplinary action as appropriate. Staff are encouraged to “stop and speak up” when they see potential risk. Leadership actively promotes transparency and responds constructively to all reports.

VII. STAFF RESPONSIBILITIES

All staff must:

- Remain alert to risks, hazards, or errors
- Take immediate action to protect patient or staff safety
- Report any incident, near miss, or safety concern as soon as possible (preferably before the end of the shift or within 24 hours)
- Document factual information accurately and completely
- Cooperate with investigations and provide relevant information
- Participate in corrective actions or training when needed

Failure to report an incident or attempt to conceal one is considered a serious violation of QOC policy.



VIII. SUPERVISOR AND LEADERSHIP RESPONSIBILITIES

Supervisors, managers, and clinical leaders must:

- Ensure staff understand this policy and how to report incidents
- Respond promptly to reported incidents
- Provide immediate guidance or support to staff
- Ensure patient safety and initiate emergency protocols when needed
- Notify the Administrator and Director of Nursing of serious or high-risk incidents right away
- Conduct or oversee investigations
- Ensure documentation is complete and accurate
- Implement corrective actions
- Communicate findings to staff when appropriate
- Monitor for trends and escalate to QAPI/Patient Safety programs

IX. WHAT MUST BE REPORTED

The following events must be reported. This list is comprehensive but not limited:

Patient-Related Incidents:

- Fall, slip, or trip (with or without injury)
- Medication error (wrong drug, dose, time, route, or omission)
- Adverse reaction or allergic response
- Worsening or change in patient condition not anticipated
- Infection or cross-contamination
- Needle stick or sharps injury
- Burn, cut, bruise, skin tear, or pressure injury
- Equipment failure or malfunction during patient care
- Emergency transfer to hospital or ER
- Near miss that could have caused harm
- Elopement or patient missing
- Inadequate staffing that impacts patient care
- Failure or delay in treatment or visit
- Breach of confidentiality or privacy (HIPAA violation)
- Behavioral incident or patient aggression
- Incorrect documentation leading to risk

High-Acuity / Pediatric Incidents:

- Ventilator/trach disconnection or malfunction
- Oxygen failure or depletion



- IV infiltration or line complication
- Enteral feeding tube malfunction or dislodgement
- Pediatric medication dosing error
- Severe respiratory distress event

Abuse, Neglect, or Exploitation:

- Suspected or confirmed physical, emotional, or sexual abuse
- Neglect or abandonment
- Financial exploitation
- Inappropriate restraint or coercion
- Any staff or caregiver misconduct toward patient
(These incidents require immediate reporting to state authorities.)

Staff-Related or Operational Incidents:

- Staff injury or exposure (OSHA reportable)
- Assault or violent behavior from patient/family
- Unsafe home environment (weapons, infestation, hazards)
- Motor vehicle accident during patient care
- Property damage (patient, staff, or agency property)
- Theft or diversion of medications or equipment
- Interruption of critical services (power, supplies, access)
- Any incident that might lead to liability, complaint, or media attention

X. IMMEDIATE RESPONSE PROTOCOL – PATIENT INCIDENT

When an incident involving a patient occurs, the staff member present must:

1. Ensure patient safety and provide immediate care.
 - Stop the activity.
 - Stabilize the patient.
 - Perform initial assessment (vitals, neurological checks if needed).
 - Administer first aid or CPR if required.
 - Call 911 if the patient requires emergency medical assistance.
2. Notify the appropriate supervisor or clinical leader immediately.
3. Notify the physician as soon as possible for any change in condition, injury, medication error, or safety risk.
4. Continue monitoring the patient as clinically appropriate.
5. Document the incident in the medical record if it affects clinical care or condition.
6. Complete an Incident Report before the end of the shift or within 24 hours.
7. Do not alter or destroy any records related to the incident.



XI. IMMEDIATE RESPONSE PROTOCOL – STAFF INJURY OR EXPOSURE

When a staff member is injured (e.g., needle stick, fall, patient aggression):

1. Stop work and ensure personal safety.
2. Provide or seek first aid or emergency care immediately.
3. Report the injury to supervisor as soon as possible.
4. Complete an Employee Injury/Exposure Report.
5. Follow OSHA exposure protocols (e.g., post-exposure prophylaxis).
6. Notify Human Resources or Administrator.
7. Participate in any required workers' compensation documentation.
8. Incident is also logged in the Incident Reporting system for tracking.

XII. INCIDENT REPORTING PROCESS & TIMELINE

- **Step 1: Immediate Verbal Notification**
Staff must verbally inform their supervisor or clinical manager as soon as possible after the incident (same shift).
- **Step 2: Written Incident Report**
Completed within 24 hours of the incident or discovery of the incident.
- **Step 3: Initial Supervisor Review**
Supervisor reviews the report, clarifies facts, ensures patient is safe, and forwards to Director of Nursing (DON) or Administrator within 24–48 hours.
- **Step 4: Leadership Review**
DON or Administrator determines severity, whether investigation or Root Cause Analysis is required, and who will lead it.
- **Step 5: Investigation**
All incidents are investigated to determine what happened, contributing factors, and whether corrective actions are needed.
- **Step 6: Resolution & Documentation**
Investigation findings and actions are documented. Patient or staff involved are informed when appropriate.
- **Step 7: QAPI & Patient Safety Review**
Incident data is trended and reviewed regularly to identify patterns and prevent recurrence.



XIII. DOCUMENTATION REQUIREMENTS

Incident Report Form must include:

- Date, time, and location
- Individuals involved
- Detailed description of event (objective, factual)
- Patient condition before and after event
- Witnesses if any
- Immediate actions taken
- Notifications made (physician, family, leadership)
- Staff name and signature
- Supervisor review and comments

Clinical Record Documentation

If patient care or outcome changed, clinical documentation must reflect assessment, treatment, MD notification, and follow-up.

Incident Log

All reports are entered into a secure log for tracking, trending, and QAPI analysis.

Confidentiality

Incident reports are internal quality documents and are not part of the patient's medical record.

XIV. INVESTIGATION

All reported incidents receive a level of investigation appropriate to their severity. Investigations:

- Are objective and timely
- Identify system factors rather than individual blame
- Interview involved staff and review documentation
- Examine processes, environment, communication, equipment, and training
- Determine root causes or contributing factors
- Result in corrective actions when needed

XV. ROOT CAUSE ANALYSIS (RCA)

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A formal Root Cause Analysis is conducted when:

- A sentinel event occurs (death or serious harm)
- Multiple similar incidents occur (trend)
- A serious systems-level failure is identified
- Required by regulation or leadership

RCA steps:

1. Define what happened
2. Gather data and timeline
3. Identify all contributing factors
4. Determine root/system causes
5. Develop corrective action plan
6. Implement and monitor solutions
7. Share lessons learned with staff
8. Report to Governing Body

XVI. PROACTIVE RISK ASSESSMENT (HFMEA)

At least once per year, QOC selects a high-risk process and performs a Healthcare Failure Mode and Effects Analysis (HFMEA) to proactively identify vulnerabilities before harm occurs.

Examples:

- Ventilator or tracheostomy management
- Complex discharge transitions
- Medication reconciliation
- Pediatric high-acuity care
- IV/Enteral therapy setup

XVII. MANDATORY EXTERNAL REPORTING

Some incidents must be reported to outside authorities, including:

State Agencies (OHCQ, APS, CPS):

- Abuse, neglect, or exploitation
- Serious injury or death
- Unsafe environment threatening patient safety

Law Enforcement:

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- Criminal acts, assault, sexual abuse
- Missing persons or elopement with risk

OSHA:

- Staff injury, exposure, needle stick

Medicare / CMS:

- Sentinel events (if required)
- Quality concerns or fraudulent activity

Professional Licensing Boards:

- Practitioner misconduct or impairment

QOC will comply with all required timelines and documentation.

XVIII. CORRECTIVE ACTIONS AND SYSTEM IMPROVEMENTS

Corrective actions may include:

- Policy or procedure changes
- Workflow redesign
- Staff education or re-training
- Increased monitoring or supervision
- Competency validation
- Addition of supplies or equipment
- EMR modifications or alerts
- Collaboration with referral sources or vendors

Corrective actions are tracked until improvement is verified and sustained.

XIX. INTEGRATION WITH PATIENT SAFETY AND QAPI

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Incident data is analyzed and trended by:

- Patient Safety Officer or Committee
- QAPI Committee

Patterns are used to identify high-risk areas, select Performance Improvement Projects, and create system-level change. Lessons learned are shared with staff to prevent recurrence.

XX. LEADERSHIP AND GOVERNANCE ACCOUNTABILITY

The Administrator, Director of Nursing, and Governing Body are responsible for:

- Ensuring a safe environment
- Reviewing incident trends and RCA outcomes
- Allocating adequate resources
- Supporting corrective actions
- Enforcing policy and best practices
- Monitoring for sustained improvement
- Evaluating the effectiveness of the Incident Reporting Program

Leadership accountability is tied to quality outcomes and safety performance.

XXI. NON-RETALIATION

No staff member will be punished, intimidated, or treated differently for reporting an incident, near miss, or safety concern in good faith. Retaliation is strictly prohibited and will result in disciplinary action against the offending party. QOC actively protects whistleblowers and encourages open communication.

XXII. STAFF TRAINING

All staff receive training on incident reporting:

- At orientation
- Annually
- Whenever the policy is revised
- After any sentinel event or system change
- During performance evaluations when needed

Training includes definitions, examples, reporting steps, documentation, timelines, and confidentiality.

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XXIII. ANNUAL EVALUATION AND POLICY REVIEW

The Incident Reporting Program is evaluated annually to ensure:

- Compliance with regulations
- Staff understanding and reporting compliance
- Timeliness and accuracy of investigations
- Effectiveness of corrective actions
- Adequacy of resources
- Opportunities to improve safety systems

Findings are reviewed by leadership and the Governing Body. This policy is reviewed at least annually and updated as needed.

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9221 Colesville Road, Silver Spring, MD 20910

Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

DOCUMENTATION AND RECORD-KEEPING POLICY

Purpose

To establish comprehensive agency-wide standards for accurate, timely, and complete documentation of all care and services provided to participants under Model Waiver and Private Duty Nursing (PDN), ensuring continuity of care, regulatory compliance, and legal protection. This policy ensures compliance with:

- **COMAR 10.09.53** — Home Health Services (Model Waiver/PDN)
- **COMAR 10.27** — Nursing Practice Act (Delegation & Standards)
- **HIPAA** — Health Insurance Portability and Accountability Act)
- **Maryland Department of Health (DOH) & DONS guidelines**

Scope

This policy applies to all staff engaged in documenting participant care, including:

- Skilled Nurses (RNs, LPNs, CNAs)
- Clinical Staff (PTs, OTs, STs & MSWs)
- Administrative (DON, RN Supervisors, Case Managers Schedules & Intake)

Policy Statement

All clinical documentation is a legal record of the care we provide. It serves as the primary tool for ensuring continuity of care, justifying services, and verifying regulatory compliance.

Every entry must be a **clear, factual, and chronological account** of the participant's condition, the services delivered, and communication with the participant and their caregivers.

1. All documentation must be **accurate, legible, timely, and complete.**
2. Entries must clearly reflect:
 - Participant condition and response to care
 - Interventions performed and outcomes
 - Caregiver communication and participation
 - Refusals, preferences, or incidents
 - Education provided and caregiver's understanding
3. Supervisory notes must demonstrate **in-person visits**, caregiver engagement, and oversight of delegated tasks.
4. All records are the **property of the agency**, protected under HIPAA and DOH retention and confidentiality rules.

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9221 Colesville Road, Silver Spring, MD 20910

Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

Documentation Procedures

1. Daily Documentation/Charting by Direct Care Staff

Your daily notes are the most important record of a participant's progress. They must be completed **before the end of your shift** and include:

- **Care Provided:** Document all medications, treatments, personal care (ADLs), and key observations.
- **Changes in Condition:** Note any new or changing physical, mental, or emotional symptoms. Include any concerns reported by the participant or their caregiver.
- **Communication:** Record participant and caregiver input, questions, or concerns. Use direct quotes for important statements.
- **Refusals or Deviations:** Clearly document any instance where the participant or caregiver refuses a service or requests a deviation from the plan of care.
- **Education:** Note any education you provide on topics like medication side effects, infection control, or equipment use, and confirm the listener's understanding.

2. Supervisory Visit Documentation

RN Supervisors must conduct **in-person visits at least every 45 days**. The supervisory note must confirm:

- An assessment of the participant's overall health, safety, and home environment.
- Direct observation of delegated tasks performed by LPNs/RNs.
- A review of the Plan of Care to ensure it's being followed correctly and compliance.
- An interview with the caregiver to discuss their satisfaction, concerns, and any requests.

Caregiver Signature: Whenever possible, obtain the caregiver's signature to acknowledge the visit. If they are unavailable, **document the reason why** (e.g., "Caregiver was at a doctor's appointment and unavailable to sign").

3. General Documentation Standards

- **Identify Yourself:** Every entry must include the date, time of service, your full name, your professional title and signature/initials.
- **Documentation:** Must be completed before the end of each shift.
- **Correcting Errors:** To fix a mistake, draw a single line through the error, write "error," and add your initials and the date. Never use white-out or scribble over an entry.
- **Use Approved Abbreviations Only:** A list of approved abbreviations is available. If you're unsure, write it out.

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4. Confidentiality & HIPAA Compliance

Protecting participant information is everyone's responsibility.

- **Secure Records:** All clinical records, whether paper or electronic, must be kept confidential and secured from unauthorized access.
- **Safeguard Credentials:** Use the agency's provided Electronic Health Record (HER) system. Never share your login information for the Electronic Health Record (EHR) system. Caregivers may only review records relevant to their family member, per HIPAA.
- **Be Aware of Your Surroundings:** All documentation must comply with security protocols. Never leave documentation visible in your car or any public area – never leave documentation unattended in public view.

5. Documentation During Emergencies

In an emergency, **immediate participant care is the first priority**. As soon as the situation is stable, document the following:

1. The events that occurred.
2. The interventions you performed.
3. Everyone you notified (e.g., 911, family, supervisor, agency).
4. The outcome.

After documenting in the participant's chart, you must also complete an **incident report** per agency policy. Complete a separate incident report for each incident.

6. Audits & Quality Assurance

Documentation is regularly reviewed to ensure we meet our standards for quality and compliance.

- **RN Supervisors** conduct monthly chart audits to verify compliance with COMAR, HIPAA, and agency policies:
 - Completeness of notes
 - Caregiver involvement
 - Supervisory visit documentation
- The **QA/Compliance Officer** performs quarterly reviews to identify trends, risks and/or areas for improvement to ensure compliance with COMAR, HIPAA and DOH rules.

Audits are used to identify opportunities for **coaching, retraining, and enhancing our quality of care**. Deficiencies may lead to corrective action, including retraining or disciplinary measures.

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

7. Staff Responsibilities

- **Direct Care Staff (RNs, LPNs):** Maintain complete, real-time documentation.
- **Supervisory RNs:** Ensure caregiver involvement is reflected in documentation; verify staff and staff documentation is compliant.
- **Compliance/QA Officer:** Monitor adherence through audits; recommend corrective action as needed.
- **Agency Leadership & Management:** Provide training, tools, and support to ensure compliance.

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PH: 301 658-7141 / Fax: 301 658-2328

Data Collection and Submission Policy

1. Purpose

This policy establishes Quality One Care Home Health, Inc. (QOC) procedures for collecting, validating, safeguarding, and submitting required federal and State data for Medicare-certified home health agency operations, including the Maryland Health Care Commission (MHCC) Home Health Agency Annual Survey, CMS Outcome and Assessment Information Set (OASIS), and CMS Home Health Consumer Assessment of Healthcare Providers and Systems (HHAHPS).

2. Scope

This policy applies to all QOC personnel and contractors involved in clinical documentation, quality reporting, billing, patient experience measurement, and compliance functions, including administrative leadership, quality and compliance staff, clinicians, and information technology support.

3. Definitions

- MHCC Home Health Agency Annual Survey: Annual reporting submission required by MHCC for home health agency utilization, staffing, financial, payer mix, and quality-related data.
- OASIS: CMS-required standardized assessment data set used for home health quality reporting, outcomes measurement, and payment functions for applicable patients.
- HHAHPS: CMS-required patient experience survey program for eligible home health agencies, administered by an approved survey vendor.

4. Roles and Responsibilities

- Administrator: Overall accountability for compliance with reporting and submission requirements, including approval of annual reporting submissions.
- Quality and Compliance Lead: Oversees reporting calendars, monitors submission timeliness, conducts periodic audits, and coordinates corrective actions.
- Clinical Manager: Ensures timely completion of OASIS assessments, clinical documentation completeness, and staff training.

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- Billing and Revenue Cycle Staff: Coordinates claim submission processes and ensures alignment between clinical documentation and billing where applicable.
- Information Technology Support: Maintains EHR access controls, data security safeguards, and interfaces required for electronic submissions.

5. Data Collection and Submission Requirements

QOC will comply with all applicable federal and State data collection and reporting requirements. QOC will maintain written procedures and a reporting calendar that identifies submission timelines, responsible staff, and required data elements.

5.1 MHCC Home Health Agency Annual Survey

- Collect and maintain utilization, staffing, financial, payer mix, and quality-related data required by MHCC.
- Submit the MHCC Annual Survey in accordance with MHCC instructions and deadlines.
- Quality and Compliance Lead coordinates survey preparation; Administrator reviews and approves submission.

5.2 OASIS Data Collection and Submission

- Use a CMS-compliant electronic health record (EHR) platform to collect, validate, and transmit OASIS assessments for all applicable patients, as required by CMS.
- Complete OASIS assessments within required CMS timeframes for Start of Care, Resumption of Care, Follow-up, Transfer, Discharge, and Death at Home assessments.
- Use EHR validation and error-checking functions to minimize submission errors.
- Conduct supervisory review to confirm completeness and accuracy prior to submission, as required by workflow.

5.3 HHCAHPS Administration and Submission

- Contract with a CMS-approved HHCAHPS vendor to administer patient experience surveys and submit HHCAHPS data to CMS on required schedules.
- Execute a Business Associate Agreement with the HHCAHPS vendor and ensure HIPAA-compliant handling of protected health information.

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- Monitor vendor performance, survey response rates, and submission confirmations.

6. Training and Competency

- Provide initial and ongoing training for clinical staff on OASIS requirements, documentation standards, and submission workflows.
- Provide training for administrative staff on MHCC Annual Survey requirements and submission procedures.
- Document training completion and competency assessments as applicable.

7. Data Integrity, Privacy, and Security

- Maintain HIPAA-compliant privacy and security safeguards, including role-based access controls and secure authentication.
- Maintain Business Associate Agreements with vendors that access protected health information, including EHR and HHCAHPS vendors.
- Conduct periodic internal audits to evaluate data accuracy, completeness, and submission timeliness.

8. Corrective Action and Continuous Improvement

- Implement corrective actions for reporting errors or missed deadlines, including retraining, workflow modification, and enhanced supervisory review.
- Incorporate reporting performance and data quality indicators into the QAPI program.

9. Record Retention

QOC will retain reporting submissions, supporting documentation, and audit records in accordance with applicable federal and State requirements and internal record retention policies.



Governance, Compliance & Organizational Accountability Policy

I. Purpose

The purpose of this policy is to define the governance structure, leadership responsibilities, compliance framework, and accountability standards that ensure Quality One Care Home Health, Inc. (QOC) operates ethically, legally, safely, and in full alignment with all regulatory and accreditation requirements. This policy ensures that QOC maintains strong organizational oversight, supports quality of care, protects patient rights, and sustains long-term operational and financial viability.

II. Governance Philosophy

QOC is committed to:

- Ethical leadership and transparent decision-making
- Regulatory compliance and integrity
- Patient safety and quality outcomes
- Responsible financial stewardship
- Accountability at all levels
- Continuous quality improvement
- Protection of patient rights and equity
- Collaboration with community and healthcare partners

III. Regulatory Compliance

This policy supports compliance with:

- CMS Conditions of Participation (42 CFR Part 484)
- COMAR 10.24.16 (Home Health Agency Standards)
- COMAR 10.07.10 (Licensure of Home Health Agencies)
- Federal and state healthcare laws and regulations
- HIPAA, OSHA, ADA, and employment laws
- Joint Commission accreditation standards
- Corporate governance laws for Maryland entities



IV. Governing Body Responsibilities

QOC is owned and governed by a Governing Body (or Board of Directors), which holds ultimate legal and fiduciary responsibility for agency operations. The Governing Body is responsible for:

Strategic Oversight

- Approving mission, vision, and values
- Setting strategic direction and service expansion
- Ensuring alignment with community needs

Quality & Clinical Oversight

- Approving the QAPI program
- Reviewing quality data and performance outcomes
- Ensuring corrective actions are implemented
- Supporting patient safety initiatives

Financial Oversight

- Approving budgets and financial plans
- Ensuring financial viability and responsible resource allocation
- Monitoring assets and liabilities
- Avoiding financial conflicts of interest

Compliance & Regulatory Oversight

- Ensuring adherence to all federal/state regulations and licensure criteria
- Reviewing compliance reports
- Supporting internal and external audits
- Reviewing and approving key policies

Emergency Preparedness Oversight

- Approving the Emergency Preparedness Plan
- Ensuring adequate resources for emergency readiness

Leadership Appointment & Evaluation

- Appointing the Administrator and Director of Nursing (DON)
- Evaluating leadership performance
- Ensuring succession planning and depth of leadership



V. Executive Leadership Roles

Administrator / Executive Director

Responsible for:

- Daily operations and management
- Regulatory compliance
- Financial performance and resource allocation
- Policy implementation
- Staff leadership and communication
- Strategic partnerships
- Reporting to the Governing Body

Director of Nursing (Clinical Director)

Responsible for:

- Clinical operations and quality of care
- Oversight of nursing and clinical disciplines
- Compliance with clinical regulations and documentation standards
- Staff competency, supervision, and education
- Development and management of clinical policies
- Oversight of QAPI clinical activities
- Infection control and patient safety initiatives

VI. Compliance Program

QOC maintains a formal **Compliance Program** that includes:

- Written policies and procedures
- Compliance Officer or designated lead
- Legal and regulatory monitoring
- Staff education and competency
- Audits and internal reviews
- Billing and documentation compliance
- HIPAA privacy and data security
- Mechanism for anonymous reporting
- Investigation and corrective actions
- Non-retaliation policy



VII. Accountability & Ethical Standards

QOC adheres to ethical business and clinical practices including:

- Honesty and transparency
- Non-discrimination
- Avoidance of fraud, waste, and abuse
- Accurate billing and documentation
- Confidentiality and privacy protection
- Respect for patient rights and autonomy
- Staff professionalism and respectful conduct

VIII. Conflict of Interest Policy

- All Governing Body members, leadership, and staff must disclose potential conflicts.
- Decisions must be made in the best interest of QOC and its patients.
- Financial or personal gain may not influence patient care or referrals.
- Kickbacks, self-referrals, or inappropriate financial relationships are strictly prohibited (in compliance with Stark and Anti-Kickback laws).
- Conflicts are documented, reviewed, and managed transparently.

IX. Integration with Qapi & Emergency Preparedness

QAPI:

- Governing Body approves QAPI plan and resources.
- Leadership implements QAPI activities.
- QAPI findings inform policy, staffing, and leadership decisions.

Emergency Preparedness:

- Governing Body approves the Emergency Plan.
- Leadership ensures training, readiness, and resource allocation.
- Post-emergency analysis integrated with QAPI.

X. Organizational Performance & Staff Accountability

QOC ensures high performance through:

- Clear job descriptions and role expectations
- Orientation and competency validation
- Ongoing training and supervision

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- Performance evaluations and coaching
- Progressive discipline if necessary
- Staff recognition and development opportunities
- Promotion of a culture of teamwork, safety, and excellence

XI. Transparency & Stakeholder Engagement

QOC maintains open communication with:

- Patients and families
- Staff and contractors
- Hospitals and referral sources
- Community partners
- Payers and regulatory agencies

Feedback is encouraged and used to drive improvement.

XII. Documentation & Recordkeeping

QOC maintains records of:

- Governing Body meetings and approvals
- Strategic and financial plans
- QAPI reports and actions
- Compliance investigations and audit results
- Training and competency records
- Policy evaluations and revisions
- Contracts and agreements

Records are stored securely and retained per regulation.

XIII. Policy Review & Approval

This Governance & Compliance Policy is:

- Reviewed at least annually
- Updated as needed based on regulatory changes or organizational growth
- Approved by the Governing Body
- Communicated to all staff and incorporated into the Corporate Compliance Program

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EMERGENCY PREPAREDNESS & DISASTER RESPONSE PLAN

Quality One Care Home Health Agency (QOC) is committed to providing safe and effective care to our patients in all circumstances, including during emergencies or disasters that disrupt agency services. This includes ensuring the safety and well-being of patients and employees during such events.

This Emergency Preparedness Plan and Disaster Response Plan ("Plan") outlines the procedures QOC will follow to ensure continuity of care and minimize risks to patients and staff in the event of an emergency.

I. PURPOSE

The purpose of this Emergency Preparedness & Disaster Response Plan is to ensure that Quality One Care Home Health, Inc. (QOC) can effectively prevent, prepare for, respond to, and recover from all emergencies or disasters that may disrupt operations or threaten the safety of patients, staff, or the community. This plan ensures the continuity of essential home health services, including high-acuity and pediatric care, across all service areas and under all hazard conditions.

II. SCOPE

This plan applies to:

- All QOC locations and service areas
- All clinical and administrative staff (employees, contractors, PRN)
- All patient populations (adult, pediatric, high-acuity, chronic disease, medically fragile)
- All geographic areas served, including urban and rural regions
- All emergency types (natural, technological, human-caused, infectious disease, system failures)

This plan is agency-wide and scalable for expansion into additional regions or counties.

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III. REGULATORY COMPLIANCE

This Emergency Preparedness Plan is designed to meet or exceed:

- CMS Conditions of Participation for Home Health Agencies – 42 CFR §484.102
- CMS Emergency Preparedness Final Rule (all four core elements)
- COMAR 10.24.16 – Home Health Agency Standards (Quality, continuity, emergency readiness)
- COMAR 10.07.10 – Maryland Home Health Agency Licensing Regulations
- Joint Commission Emergency Management Standards
- OSHA, CDC, and state/local public health requirements

This plan is reviewed and updated annually or after any activation, drill, or regulatory change.

IV. GOALS AND OBJECTIVES OF THE PLAN

QOC's Emergency Preparedness Plan is designed to:

- Protect the health and safety of patients, staff, and the community.
- Maintain continuity of essential services during emergencies.
- Ensure care for high-risk and high-acuity patients (vent, trach, IV, pediatric).
- Coordinate with hospitals, EMS, emergency management agencies, and suppliers.
- Allocate staff and resources based on patient acuity and priority.
- Establish clear leadership, command, and communication.
- Maintain secure access to medical records and patient information.
- Implement rapid response, stabilization, and recovery.
- Integrate emergency data and lessons learned into the QAPI program.

V. ALL-HAZARDS APPROACH

QOC uses an **All-Hazards Framework** based on risk assessment rather than creating separate plans for every possible event.

This includes:

- Natural disasters (snowstorms, ice, flood, heat, tornado, earthquake)
- Severe weather/power outages (critical for high-acuity patients)
- Infectious disease/pandemic (e.g., COVID-19)
- Fire, hazardous materials, chemical exposure
- Terrorism, active shooter, workplace violence
- Cyberattack/data breach
- Transportation disruptions

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- Supply chain shortages (oxygen, PPE, meds, DME)
- Staff shortages or labor disruptions
- Facility closure or damage
- Multi-county state of emergency

QOC adapts this plan to the nature and severity of each event.

VI. GOVERNANCE & EMERGENCY PREPAREDNESS OVERSIGHT

A. Governing Body

The Governing Body retains ultimate responsibility for emergency preparedness, ensures adequate resources, approves this plan, and receives reports on drills, activations, and corrective actions.

B. Emergency Preparedness Committee (integrated with QAPI)

QOC maintains an Emergency Preparedness Committee, which may operate as a subcommittee of the QAPI Committee. Members include:

- Administrator/Executive Director
- Director of Nursing/Clinical Director
- Operations Manager
- Quality Improvement Coordinator
- Emergency Preparedness Coordinator (designated lead)
- Therapy and HHA representatives
- IT/Data security representative (as needed)

Responsibilities:

- Conduct annual Hazard Vulnerability Analysis (HVA)
- Develop and review policies and procedures
- Coordinate training and drills
- Evaluate emergency activations and after-action reports
- Integrate findings into QAPI and policy updates
- Liaise with local emergency management and healthcare coalitions

C. Emergency Preparedness Coordinator

A designated Emergency Preparedness Coordinator (EPC) oversees:

- Plan implementation
- Staff training and communications

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- Incident Command activation
- Coordination with external partners
- Documentation of all activities

VII. CHAIN OF COMMAND & DELEGATION OF AUTHORITY

QOC maintains a clear, written chain of command with **at least 3 levels of leadership** to ensure continuity:

1. Administrator / Executive Director
2. Director of Nursing / Clinical Director
3. Alternate Clinical Supervisor / Operations Manager
4. On-call RN Clinical Lead (as needed)

Delegation of authority includes:

- Authority to activate emergency plan
- Clinical decision-making
- Resource allocation
- Staff deployment
- Communication with external authorities
- Media/public information (if needed)

This ensures that emergency operations continue even if key leaders are unavailable.



ALL-HAZARDS RISK ASSESSMENT & PATIENT PRIORITIZATION

I. HAZARD VULNERABILITY ANALYSIS (HVA)

QOC conducts an **annual All-Hazards Risk Assessment** using tools such as FEMA, ASPR TRACIE, and local emergency management guidance.

Risks are ranked by **Likelihood, Impact on Clinical Operations, and Impact on Patient Safety.**

Natural Disasters / Weather

- Severe snow/ice storms
- Flooding
- High winds/tornadoes
- Extreme heat/cold
- Power outages (critical for high-acuity patients)

Public Health Emergencies

- Pandemic/infectious outbreak
- Shortage of PPE or staffing

Technology / Infrastructure

- Communication failure (phone/internet)
- EMR system downtime/cyberattack
- Utility disruption (water, electricity, gas)

Clinical / Operational

- Surge in hospital discharges
- High-acuity patient deterioration
- Staff illness/shortage
- Medication or supply chain disruption

Security / Safety

- Fire
- Hazardous materials
- Active shooter or violence
- Evacuation of office or region



Transportation Failures

- Road closures (especially in rural counties)
- Fuel shortages
- Vehicle breakdowns

Findings of the HVA directly inform:

- Emergency policies & procedures
- Staffing contingency planning
- High-acuity patient support strategies
- Training & drills
- Resource allocation

These results are **reviewed annually and incorporated into the QAPI program.**

II. PATIENT RISK STRATIFICATION & PRIORITIZATION

QOC maintains an **up-to-date, patient-specific emergency risk profile** for every active patient. Patients are prioritized into **Tiers** based on medical needs, equipment dependency, and ability to self-manage during emergencies.

Tier 1 – High Priority / Life-Dependent (Daily or Multiple Visits)

These patients require immediate contact and care continuity:

- Ventilator or tracheostomy
- IV infusion or feeding pumps
- Oxygen-dependent with no backup
- Unstable condition or high medical acuity
- Pediatric complex care
- No caregiver support
- Cognitive impairment with no aide
- Hospice patients with high symptom burden

Action: Daily check-in or in-person support. Must have backup power and emergency plans.

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Tier 2 – Moderate Priority (Skilled/Regular Visits, Some Support)

- Chronic illness with risk of deterioration (CHF, COPD, diabetes)
- Routine wound care
- Rehab therapy (recent post-acute, post-surgical)
- Limited caregiver support
- Medication management needs

Action: Contact within 24–48 hours. Adjust visit frequency based on stability.

Tier 3 – Low Priority (Stable / Minimal Risk)

- Independent with ADLs
- Infrequent skilled services
- Strong caregiver or family support
- Can self-manage medications

Action: Phone check-in. Resume visits when safe.

Patient Risk Files Include:

- Medical condition and acuity level
- Equipment and supply needs
- Caregiver support availability
- Backup power source availability
- Emergency contacts
- Physician contact
- Preferred hospital
- Evacuation needs (transportation, mobility)

These files are reviewed every 60 days OR when condition changes.



III. HIGH-ACUITY & PEDIATRIC CONTINUITY PLANNING

QOC provides specialized procedures for high-risk groups:

Ventilator / Tracheostomy Patients

- Confirm backup power sources and battery duration
- Provide emergency instructions to caregivers
- Maintain vendor contacts for oxygen and respiratory supplies
- Daily monitoring during emergencies

IV Infusion / Enteral Feeding Patients

- Backup medication/supply inventory
- Coordinate with infusion pharmacies
- Alternative administration plans if power is lost

Complex Wound Care

- Ensure dressing supply stock
- Educate caregivers on temporary dressing changes
- Flag for priority visits

Pediatric Patients

- Age-specific emergency needs
- Medication/dosing continuity
- Caregiver education
- Emotional/behavioral support
- Specialist physician coordination

High-acuity patients are flagged in EMR and placed on the High-Priority Emergency List.

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IV. SUPPLIES & EQUIPMENT READINESS

QOC ensures availability of:

- PPE
- Dressing supplies, gloves, sterile materials
- IV supplies, enteral sets
- Oxygen tubing/masks
- Backup batteries or small generators (via DME partnerships)
- Emergency medication supply coordination
- Staff go-bags: BP cuff, stethoscope, thermometer, pulse ox, PPE, documentation tools
- Pandemic supplies (N95s, hand sanitizer, testing kits)

Supply levels are checked monthly and increased seasonally (e.g., winter storm season).

V. PARTNERSHIPS & COLLABORATION (REQUIRED BY CMS & MHCC)

QOC maintains or will formalize Memoranda of Understanding (MOUs) / partnership agreements with:

- Local hospitals / health systems
- EMS and county emergency management agencies (EMA/EOC)
- Durable Medical Equipment (DME) / oxygen suppliers
- Pharmacies and infusion companies
- Transportation providers (as needed)
- Hospice and long-term care partners
- Utility companies (to prioritize high-acuity patients)
- Home health and community agencies for mutual aid

QOC participates in regional and county healthcare coalitions and emergency planning meetings where available.



EMERGENCY RESPONSE, COMMUNICATION, SHELTER/EVACUATION

I. Emergency Plan Activation

The Emergency Preparedness Coordinator, Administrator, or highest-ranking available supervisor may **activate the Emergency Plan** when any of the following occurs:

- Severe weather or natural disaster warning issued
- Widespread power or utility outage
- Government-declared state of emergency
- Public health emergency (e.g., pandemic)
- Hospital surge or mass discharge event
- Cyberattack or major IT disruption
- Evacuation order affecting service area or office
- Any event that threatens care continuity or patient safety

Activation includes:

1. Initiating Incident Command Structure (ICS)
2. Notifying staff
3. Prioritizing high-risk patients
4. Implementing emergency protocols
5. Documenting all actions

II. Incident Command Structure (ICS)

QOC uses a **modified Home Health Incident Command System (HICS)** to ensure clear leadership and delegation.

Incident Commander (IC)

→ Administrator or Clinical Director

Responsible for overall decision-making and resource allocation.

Operations Chief

→ Clinical Supervisor or On-Call RN

Manages patient care, staff deployment, and visit prioritization.

Planning/Intelligence Chief

→ QAPI or EP Coordinator

Tracks situation status, patient data, and future needs.

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Logistics Chief

→ Operations Manager or Designee

Coordinates supplies, transportation, equipment, and staffing.

Finance/Administration Chief

→ Billing/Finance Manager

Tracks costs, logs hours, manages claims, regulatory compliance.

Public Information Officer (if needed)

→ Administrator or approved spokesperson

Handles communication with hospitals, EMS, media (if required).

If any command role is unavailable, the next tier leader assumes responsibility.

III. Staff Communication Plan

QOC maintains multiple **redundant communication methods** to prevent failure:

- Primary: Phone calls (mobile and landline)
- Secondary: Text messaging
- Tertiary: Email
- Secure messaging within EHR
- Telehealth platform messaging
- Conference call or group chat lines
- In-person dispatch (if electronic systems fail)

Staff Notification Procedures:

- “Emergency Activation” message sent
- Staff confirm receipt
- Staff report availability and location
- Assignments distributed by supervisor/Operations Chief

Staff must keep contact information current and maintain backup charging capability.

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IV. Patient Communication Plan

QOC will:

- Contact **Tier 1 patients first**
- Verify safety, power status, supply levels, medical stability
- Provide instructions on shelter, evacuation, or care modifications
- Use caregiver support and emergency contacts when necessary

If unable to reach patient:

- Attempt 3 calls over defined time period
- Notify emergency contact
- Dispatch staff or request wellness check via EMS/local police if patient is high-risk

All communication is documented in the EHR.

V. Coordination with External Agencies

QOC will coordinate with:

- Hospitals (for discharge planning, surge support, or transfers)
- EMS (for life-threatening situations or transport needs)
- Local health department / emergency management agency
- State or local emergency operations center (EOC)
- Utility companies (to prioritize life-support patients)
- Pharmacies and DME suppliers (backup delivery)
- Other home care providers (mutual aid if needed)

QOC participates in healthcare coalitions to improve regional response.

VI. Shelter-In-Place Protocols

If conditions are unsafe for travel:

- Staff avoid high-risk driving
- Patient visits are prioritized by Tier
- Telephonic or telehealth assessments are used
- Caregivers are given instructions and support
- Emergency supplies and medications are reviewed in advance



- High-acuity patients are proactively monitored

Clinically essential visits for Tier 1 patients continue when safe.

All deviations from planned visits are documented with clinical justification.

VII. Evacuation Procedures

If a patient's home or area is unsafe or evacuation is ordered:

Preparation

- Identify evacuation routes
- Determine patient mobility and transport needs
- Coordinate with EMS or family transportation
- Identify destination (hospital, shelter, alternate residence)

High-Acuity / Vent-Dependent Patients

- Contact EMS and hospital directly
- Ensure transfer of equipment/supplies
- Provide written and electronic handoff (medications, plan of care, orders)

Staff Evacuation

- Office evacuation follows fire/emergency building plan
- Staff perform remote work if possible
- EHR access is maintained off-site via secure connection

Patient Tracking

- Patient location and status documented in EHR
- Updated daily until emergency ends

VIII. Active Shooter or Violence

QOC follows **Run – Hide – Fight** guidance for staff safety.

- If in office: follow commercial building plan and call 911.
- If in patient home: staff leave immediately, call 911, notify supervisor.
- Document incident and support patient/staff as needed.
- Post-event debriefing and counseling provided.

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IX. Pandemic / Infectious Disease Response

QOC maintains detailed infection control and pandemic protocols that include:

- Screening staff and patients
- PPE requirements based on CDC/State guidance
- Isolation procedures for infected patients
- Telehealth and remote monitoring to reduce exposure
- Cohorting of staff to reduce cross-contamination
- Staff vaccination and education
- Supply chain monitoring for PPE and sanitizers
- Coordination with local health departments
- Compliance with CMS emergency waivers (1135)

Infectious disease response is integrated with the QOC Infection Control Program.



CONTINUITY OF OPERATIONS, STAFFING, RECOVERY & QUALITY INTEGRATION

I. Continuity of Operations Plan (Coop)

QOC maintains a **formal Continuity of Operations Plan (COOP)** to ensure essential services continue during emergencies.

COOP Objectives:

- Protect patient safety
- Maintain critical clinical functions
- Deploy staff where needed most
- Preserve access to medical records
- Communicate effectively with all stakeholders
- Recover operations quickly post-emergency

Essential Services (must be maintained at all times)

- Skilled nursing for high-acuity / Tier 1 patients
- Ventilator/tracheostomy / oxygen management
- IV therapy, enteral feeding, complex wound care
- Medication administration and reconciliation
- Physician-ordered skilled visits
- Care coordination and communication with hospitals
- EMR documentation and physician orders
- Emergency supply support

Non-essential visits may be rescheduled or converted to telehealth.

II. Leadership Continuity and Delegation of Authority

QOC maintains at least **three levels of leadership depth** to ensure operational continuity:

1. Administrator / Executive Director
2. Director of Nursing / Clinical Director
3. Alternate Clinical Supervisor / Operations Manager
4. On-Call RN Supervisor (as needed)

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Delegations of authority are pre-approved in writing and reviewed annually.

Authority includes:

- Activating the plan
- Deploying staff and resources
- Modifying services
- Approving expenditures
- Communicating with agencies/hospitals
- Making clinical decisions

III. Staffing Contingency & Surge Strategies

To maintain care delivery during staff shortages or volume surges, QOC will:

- Use PRN / On-call staff
- Cross-train clinicians (RN, LPN, therapist roles)
- Reassign staff geographically based on need
- Utilize telehealth to reduce field visits
- Increase supervision and rotation scheduling
- Use regional “float pool” personnel
- Offer incentives or emergency pay if needed
- Utilize mutual aid agreements with partner agencies
- Rapid hire or contract temporary clinical staff (if prolonged emergency)
- Prioritize Tier 1 patients for in-person care

No patient is abandoned. High-acuity patients always come first.

IV. Remote Work and Tele-Health Continuity

QOC maintains the ability for clinical and administrative staff to work remotely, including:

- Secure VPN access to EMR/EHR
- Remote scheduling and telehealth capability
- Phone/video health assessments
- Caregiver coaching and safety checks
- Remote interdisciplinary case conferencing
- Telephonic or video physician collaboration

Telehealth may temporarily substitute for in-person visits when clinically appropriate.



V. Medical Records & Data Protection

QOC ensures:

- All patient records are maintained electronically (EHR)
- Secure cloud-based backup with redundancy
- Remote access available to authorized staff
- Daily data backup with encryption
- Disaster recovery protocols approved by IT
- Paper backup procedures for downtime

HIPAA compliance is maintained at all times, even during emergencies.

VI. Supply Chain & Equipment Continuity

QOC maintains vendor agreements with:

- Oxygen and DME suppliers
- IV and enteral therapy suppliers
- Pharmacies and 24-hour delivery services
- PPE distributors
- Utility providers (to flag life-support patients)
- Transportation providers (non-emergency medical, EMS backup)

Safety stock is maintained, especially for winter and pandemic seasons.

VII. Recovery & Reconstitution of Services

After an emergency event, QOC will:

1. Contact and reassess all patients (starting with Tier 1)
2. Resume normal visit schedules as conditions allow
3. Determine which patients need re-evaluation or new orders
4. Identify unmet needs and coordinate with hospitals/physicians
5. Document all changes in the EHR

If patient condition declined, physician is notified and plan of care updated.



VIII. Staff Recovery & Support

QOC recognizes emergencies impact staff as well. We will:

- Provide rest periods
- Offer counseling or EAP services
- Adjust schedules to prevent burnout
- Debrief staff to gather feedback
- Recognize staff contributions

Staff well-being supports patient safety.

IX. Documentation Requirements

Documentation is retained per CMS/COMAR requirements. QOC documents:

- Time of activation and deactivation
- Actions taken and decisions made
- Patient contacts and status
- Missed or modified visits
- Resource allocation
- Staff assignments
- Communication with external agencies
- Expenses and claims (as needed)
- After-action review and improvement plan

X. INTEGRATION WITH QAPI PROGRAM

QAPI reviews:

- Emergency activation outcomes
- Patient safety events
- Response effectiveness
- Staff feedback
- Communication failures/successes
- Delays or access issues
- Hospitalization or adverse events
- Training or competency gaps
- Policy or system improvement needs

Findings are turned into Performance Improvement Projects (PIPs) when needed. This ensures **continuous improvement** and readiness for future events.

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

PH: 301 658-7141 / Fax: 301 658-2328

XI. Training & Drills (Mandatory)

QOC provides:

- Emergency Preparedness training during orientation
- Annual refresher training for all staff
- Scenario-based clinical training (e.g. high-acuity evacuation)
- Infection control and PPE training
- Active shooter / workplace violence training

CMS-required exercises:

- At least 1 full-scale community-based drill per year (or facility-based if community drill not available)
- At least 1 additional exercise (tabletop, functional, or additional drill)
- After-action review and corrective action plan for EACH drill

Training and drills are **fully documented** and reviewed by the Governing Body.

XII. Annual Plan Review

This Emergency Preparedness Plan:

- Is reviewed **at least annually**
- Is updated after each drill or real emergency
- Includes documented HVA (Hazard Vulnerability Analysis)

CONSUMER GRIEVANCE POLICY AND PROCEDURE

I. PURPOSE

The purpose of this policy is to ensure that every patient of Quality One Care Home Health, Inc. (QOC) has the right and opportunity to voice concerns, complaints, or grievances about their care or service without fear of retaliation, and to ensure that all grievances are handled promptly, fairly, consistently, and in a manner that promotes quality improvement and patient satisfaction.

II. PHILOSOPHY

QOC is committed to a culture of transparency, respect, and accountability. We believe patient and family feedback is essential to improving care. All grievances are taken seriously, addressed with urgency, and used to strengthen our services. No patient will ever be denied care, discharged, or retaliated against for expressing a concern or filing a grievance.

III. REGULATORY COMPLIANCE

This policy complies with:

- CMS Conditions of Participation (42 CFR 484.50 – Patient Rights and Grievances)
- COMAR 10.07.10.17 – Client Rights and Complaint Resolution
- COMAR 10.24.16 – Quality and Patient Protection Standards
- Joint Commission Patient Rights and Ethics Standards
- Federal and state laws regarding nondiscrimination and patient protection

IV. DEFINITIONS

Complaint: A concern that can be resolved promptly by the staff present, without further investigation or formal action.

Grievance: A more serious concern that requires further review, investigation, follow-up, or written response. Any issue related to quality of care, safety, abuse, neglect, rights violations, or failure to resolve a complaint is considered a grievance.

Serious or Urgent Grievance: A grievance involving potential harm, abuse, neglect, safety threats, or legal/regulatory violations. These require immediate leadership involvement.

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

PH: 301 658-7141 / Fax: 301 658-2328

V. RIGHT TO FILE A GRIEVANCE

Patients, family members, caregivers, or legal representatives have the right to:

- File a grievance at any time
- Have their concern taken seriously and investigated
- Receive a timely response and resolution
- Be free from retaliation or discrimination
- Escalate grievances to state or federal agencies if unsatisfied

VI. HOW TO FILE A GRIEVANCE

A grievance may be submitted in any of the following ways:

- Verbally to any staff member
- In writing (letter, email, fax)
- By phone to the office or supervisor
- Anonymously
- After discharge

Grievances may be made to any staff member, who must immediately report it to the Clinical Supervisor, Patient Safety Officer, or Administrator.

QOC Contact for Grievances:

Quality One Care Home Health, Inc.

Administrator / Patient Safety Officer

Phone: 301-658-7141

Email: info@qualityonecare.com

Address: 9221 Colesville Road, Silver Spring, MD 20910

VII. WHO MAY FILE A GRIEVANCE

- The patient
- Family or caregiver
- Legal representative or guardian
- Staff member on behalf of a patient
- Referral source or advocate



VIII. INTERNAL GRIEVANCE PROCEDURE

Step 1: Receipt and Acknowledgement

- Grievance is logged in the Grievance Log.
- Acknowledgement is provided to the patient within 5 business days (verbal or written).

Step 2: Investigation

- The Supervisor, Patient Safety Officer, or Administrator investigates the issue.
- All relevant information is gathered, and staff involved may be interviewed.
- Serious grievances may involve Root Cause Analysis or referral to the Patient Safety Committee.

Step 3: Resolution

- Corrective actions are identified and implemented.
- Patient is informed of findings, actions taken, and resolution.
- If additional time is needed, the patient is updated on progress.

Step 4: Written Response

A formal written response is provided within 30 calendar days (or sooner), including:

- Summary of the grievance
- Steps taken to investigate
- Findings and actions
- Contact information for further questions
- How to appeal or escalate if unsatisfied

Step 5: Documentation

- All grievances, investigations, and resolutions are documented in the Grievance Log.
- Documentation is kept separate from the clinical chart unless clinically relevant.
- Trends are tracked and reported to QAPI and leadership.

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

PH: 301 658-7141 / Fax: 301 658-2328

IX. NON-RETALIATION

Patients will never be denied care, discharged, penalized, or treated differently for filing a grievance. Staff are prohibited from any retaliatory behavior. Any retaliation will result in disciplinary action.

X. ESCALATION OPTIONS (EXTERNAL AGENCIES)

Patients may also contact the following at any time:

Maryland Department of Health – Office of Health Care Quality (OHCQ)

Phone: 1-877-402-8218

Website: <https://health.maryland.gov/ohcq>

Medicare (for Medicare beneficiaries)

1-800-MEDICARE (1-800-633-4227)

Medicare Beneficiary Ombudsman

<https://www.cms.gov/Center/Special-Topic/Ombudsman>

The Joint Commission (if accredited)

Office of Quality and Patient Safety

1-800-994-6610

Email: patientsafetyreport@jointcommission.org

Contact information is provided to every patient in writing at admission.

XI. SERIOUS OR URGENT GRIEVANCES

If the grievance involves abuse, neglect, exploitation, or immediate danger:

- Services to the patient are stabilized.
- Administrator and Director of Nursing are notified immediately.
- Mandatory reports to state or law enforcement are made as required.
- A Root Cause Analysis or formal investigation is initiated.

XII. GRIEVANCES RELATED TO DISCHARGE OR REDUCTION OF SERVICES

- QOC will provide proper written notice (e.g., NOMNC for Medicare beneficiaries).
- Patients may appeal through Medicare or appropriate entities.



- Services will continue during appeal when required by law.

XIII. QUALITY IMPROVEMENT & QAPI INTEGRATION

All grievances are reviewed by the QAPI Committee to:

- Identify patterns or systemic issues
- Develop performance improvement projects
- Improve processes, training, and communication
- Enhance safety, quality, and patient experience
- Ensure accountability and follow-through

XIV. STAFF TRAINING

All staff receive training at orientation and annually on:

- How to recognize complaints and grievances
- How to assist patients in filing grievances
- Documentation requirements
- Non-retaliation expectations
- When to escalate serious grievances

XV. CONFIDENTIALITY

All grievances are handled confidentially. Patient information is protected under HIPAA and only disclosed on a need-to-know basis or when required by law.

XVI. ANNUAL REVIEW

The grievance process and data are evaluated annually by leadership and the Governing Body to ensure:

- Timeliness and effectiveness
- Compliance with regulations
- Identification of trends
- Adequacy of resources
- Opportunities for improvement

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

PH: 301 658-7141 / Fax: 301 658-2328

XVII. POLICY APPROVAL

This policy is reviewed at least annually, updated as needed, and approved by the Administrator or Governing Body.

EXHIBIT 12

Linkages and Referral Pathways

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS
Current Linkages, Referral Pathways...
Letters of Support

Quality One Care maintains established referral pathways and contracting relationships that support care coordination, intake, and timely service initiation. The attached agreements demonstrate QOC's existing payer contracting experience, institutional referral linkages, and capacity to coordinate services across multiple settings. As the proposed HHA begins operations, QOC will extend these established referral coordination processes to home health referral sources including hospitals, physician practices, assisted living providers, and post-acute partners within the six-county service area.



SINGLE CASE AGREEMENT

This Single Case Agreement (“Agreement”) is made as of the date set forth below by and between **Johns Hopkins HealthCare (“JHHC”)** on behalf of the **Payor** identified on Exhibit A hereto and **Provider** identified on Exhibit A. JHHC and Provider hereby agree as follows:

1. **Purpose.** Provider does not participate in Payor’s provider network. The purpose of this Agreement is for Provider to provide Designated Covered Services identified on Exhibit A to Payor’s Covered Person in exchange for the reimbursement set forth herein. Covered Services are services that are covered under Payor’s program. Designated Covered Services are those Covered Services which Provider may provide under this Agreement.
2. **Policies and Standards.** Upon execution of this Agreement, Provider agrees to ensure that its providers and staff will provide health care services in accordance with the policies and standards established by JHHC and Payor.
3. **Services to be Provided Under This Agreement.** This Agreement only applies to the Covered Services described in Exhibit A the Designated Covered Services. Any additional services must be separately agreed upon and authorized.
4. **Compensation.** Provider will be compensated in accordance with the rates specified for Designated Covered Services. Provider will be responsible for billing JHHC electronically or using appropriate claim forms for Provider’s provision of services hereunder as further set forth on Exhibit A. Provider shall have one- hundred eighty (180) days from the date of service to submit a clean claim. In the event the Provider fails to submit a clean claim within this time frame, neither JHHC nor the Covered Person shall be responsible to the Provider for the claim amount, and the Provider shall not bill JHHC or the Covered Person. In cases where there is coordination of benefits (COB), if Payor is primary, the fee contained in Exhibit A of this Agreement will be paid. If Payor is secondary, JHHC, on behalf of Payor, will pay the difference between the amount paid by the primary carrier and the fee contained in Exhibit A, if applicable.
5. **Payment Terms.** JHHC shall pay clean and uncontested claims which are accompanied by all necessary documentation within thirty (30) days of receipt. To the extent required by law, interest at the rate set forth therein, pro-rated for any portion of a month shall be paid beginning with the thirty-first (31st) day on the amount of any undisputed claim that remains unpaid after thirty (30) days following receipt of such undisputed claim.
6. **Hold Harmless.** Provider agrees to accept the compensation payable under this Agreement as payment in full for services rendered hereunder, except for applicable copayments, coinsurance and deductibles. Provider agrees that, in no event including, but not limited to, non-payment by JHHC, non-funding by Payor, insolvency or breach of this Agreement, will Provider seek payment, remuneration or reimbursement from Covered Person for (i) any amount payable to Provider under the terms of this Agreement, (ii) the difference between the Provider’s billed or customary charges and the amount payable under this Agreement or (iii) services which are determined to be medically unnecessary under the utilization management program of JHHC. This provision shall not prohibit collection of copayments, deductibles or coinsurance amounts in accordance with the terms of the applicable JHHC policy. This provision shall survive the termination of this Agreement, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Covered Person.



This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Covered Person.

- 7. **Insurance.** Provider agrees to maintain policies of comprehensive general and professional liability insurance.
- 8. **Confidentiality.** The terms of this Agreement shall not be disclosed to third parties.
- 9. **Notices.** All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by Federal Express or Express Mail, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to JHHC: Johns Hopkins HealthCare, LLC
7231 Parkway Drive, Suite 100
Hanover, MD 21076

If to Provider: Quality One Care Home Health Inc
9221 Colesville Road
Silver Spring, MD 20910

Provider

Johns Hopkins HealthCare LLC

Mohamed Matope

By: Anita DeSimone-Veach

Provider's Signature

Mohamed Matope

Name: Anita DeSimone-Veach

Provider's Printed Name

Director

Title: Senior Director of Provider Relations & Network Development

Provider's Title

Date: 04/21/2023 **Date:** 4/21/2023

- 10. **Assignment.** Neither party shall assign their responsibilities under this Agreement without the prior written consent of the other party.

The parties have agreed to the foregoing terms on the date listed on the attached



780 Shiloh Road, MS-1.700
Plano, TX 75074

Jun. 4, 2020

QUALITY ONE CARE HOME HEALTH, INC
info@qualityonecare.com

Re: Welcome to the Veterans Affairs Community Care Network!

Dear Mohamed Matope:

On behalf of UnitedHealthcare, I want to personally thank you for joining the Department of Veterans Affairs (VA) Community Care Network (CCN) administered by Optum.

As you get started as a VA CCN participating care provider, here are a few next steps and resources to help you better understand how you are helping to serve Veterans in your community.

Your Participation Agreement

We're including a copy of your executed Participation Agreement for tax ID number **900715209**, signed by both you and UnitedHealthcare. The agreement for VA CCN is effective on **06/15/2020**.

Review the VA CCN provider materials at provider.vacommunitycare.com.

You'll find information and training on the unique VA CCN requirements. Resources include:

- VA CCN Provider Manual
- Regional maps and deployment schedules
- Claims processing guidelines
- Training resources and educational guides
- Frequently asked questions
- Quick reference guides
- Medication prescribing information
- VA fee schedule

To get started, you can also view the Department of Veterans Affairs Community Care Network Overview video at provider.vacommunitycare.com > Training & Guides > Self-Service Resources and Educational Videos.

Get ready to deliver care.

- Delivery of care to Veterans under your VA CCN participation agreement begins when you receive a referral from VA. You'll start getting VA referrals after you're in the VA system as a participating VA CCN provider, which could take up to 30 days from your participation start date.
- Optum is the third-party administrator for VA CCN Regions 1, 2 and 3. Your office should only schedule appointments with Veterans and bill Optum when the network on the VA referral is CC Network 1, CC Network 2 or CC Network 3. The VA CCN Provider Manual shows an example of a referral.

- The training and resources at **provider.vacommunitycare.com** can help your office staff identify VA CCN-related appointments. This will help ensure accurate registration and claim submission, which will help ensure timely payments from Optum.

We're Here to Help

If you have questions, please call your region's CCN Provider Services – the regional state list is at **provider.vacommunitycare.com** > News & Announcements:

- Region 1: 888-901-7407
- Region 2: 844-839-6108
- Region 3: 888-901-6613

CCN Provider Services is available from 8 a.m. – 6 p.m. provider's local time, Monday –Friday, excluding federal holidays. Thank you.

Sincerely,

Lizette R Arthur

Lizette R Arthur
United Healthcare VACCN Contractor

Enclosures

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UHC of California DBA UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of the Mid-Atlantic, Inc., MAMSI Life and Health Insurance Company, UnitedHealthcare of New York, Inc., UnitedHealthcare Insurance Co. of New York, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Pennsylvania, Inc., UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Washington, Inc., Optimum Choice, Inc., Oxford Health Insurance, Inc., Oxford Health Plans (NJ), Inc., Oxford Health Plans (CT), Inc., All Savers Insurance Company or other affiliates. Administrative services provided by OptumHealth Care Solutions, LLC, OptumRx, Oxford Health Plans LLC, United HealthCare Services, Inc. or other affiliates. Behavioral health products provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH) or its affiliates.

PCA-1-20-00261-OPTUM-LTR_02182020

© 2020 United HealthCare Services, Inc.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

AGREED BY:

X QUALITY ONE CARE HOME HEALTH, INC	Address to be used for giving notice under the agreement:
Signature: <small>DocuSigned by:</small> <i>Mohamed Matope</i>	Street: 12510 Prosperity Dr, Suite # 320
Print Name: <small>F54B2D4EB25C40E...</small> MOHAMED MATOPE	City: silverspring
DBA (if applicable):	State: MD
Date: 4/21/2020	Zip Code: 20904
Email: mmatope@qualityonecare.com	TIN: 900715209
National Provider Identification (NPI) Number:	1528351285

UnitedHealthcare Insurance Company contracting on behalf of itself, UnitedHealthcare of the Mid-Atlantic, Inc., MD-Individual Practice Association, Inc., Optimum Choice, Inc. and its other affiliates, as signed by its authorized representative:	
Signature: <i>Andrew Rich</i>	
Print Name: <small>9A14262W2FR7D...</small> Andrew Rich	
Date: 5/20/2020	
For office use only: 7385920	
Month, day and year in which agreement is first effective: 06/15/2020	

NON-PAR RATE NEGOTIATION AGREEMENT

October 13, 2025

VIA EMAIL: [REDACTED]

Mohamed Matope

Quality One Care Home Health

9221 Colesville Road

Silver Spring, MD 20910

Re: Member Name; [REDACTED] Date of Birth [REDACTED]: Member Identification Number:
[REDACTED].

Dear Mohamed Matope:

The purpose of this letter is to provide written confirmation of the authorization for private duty nursing services for [REDACTED] (the "Member") as prescribed by the attending physician, as follows:

- CareFirst BlueCross BlueShield, hereinafter referred to as "Corporation", has been advised that the Member shall begin receiving care from Community Care Nursing Services (Provider Name), hereinafter referred to as "Non-Par Provider", on October 2, 2025.

At this time and confirmed hereby, care has been authorized for in-network reimbursement under the Member's health benefit policy in effect for dates of service October 2, 2025 through December 31, 2025 or when Member has reached their maximum benefit level, whichever is earlier. Corporation and Non-Par Provider agrees to an all-inclusive rate of Sixty dollars (\$60.00) per hour and which care/services shall include visits by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) for the following:

- S9123/S9124 8 hours per day of PDN 10/2/2025 to 12/31/2025
- Reimbursement payments will be made directly to Non-Par Provider. Non-Par Provider agrees to look solely to Corporation for payment of the reimbursement agreed upon and that the Member and all others will be held harmless from claims for any and all services rendered pursuant to this authorization, with the exception of
 - applicable Member liability such as coinsurance, copayments, deductibles and non-covered items or services; and
 - Payments made by Corporation to Member prior to the implementation of this Agreement.
- Provider understands and acknowledges this is a one-time agreement applicable only to this Member and does not establish a precedent for future participating provider negotiations with Corporation.
- To ensure accurate processing of claims, Non-Par Provider agrees to attach a copy of this letter to the claim(s) and submit the claim(s) to:

Christine Miller
CareFirst BlueCross BlueShield
Liaison, Claims, Large Group SBU/Mail Stop NAS-60
10 Commerce Drive
Cumberland, MD 21502
W- 301-777-6051 / f 410-505-2497
Email: Nonparclaimsprocessing@carefirst.com

AUDIT RIGHTS

CareFirst shall have the right to audit any claims or payments, made pursuant to this agreement, and to effectuate its rights of recovery as stated below.

RIGHT OF RECOVERY

In the event that billings, made pursuant to the terms herein, result in overpayments or errant payments CareFirst shall have the right to recover such payments.

If this information does not accurately or adequately document the agreement regarding services for the Member, please contact Kendra Symonette Phone:410-872-3821. Otherwise, please sign where indicated below, and return a signed copy (via fax) to Kendra’s attention at 410-505-6978 as soon as possible.

Sincerely,



Jay Simmons,
VP Provider Networks Contracting

Provider Name

By: Mohamed Matope
(Signature)

Name: Mohamed Matope
(Print)

Title: Director

Date: 10/17/2025

Federal Tax ID: 90-0715209

NPI: 1528351285



NON-PAR RATE NEGOTIATION AGREEMENT

June 28, 2024

VIA FACSIMILE: 301-658-2328

Mohamed Matope

Quality One Care Home Health

9221 Colesville Road

Silver Spring, MD 20910

Re: Member Name; [REDACTED] Date of Birth [REDACTED] Member Identification Number:
[REDACTED]

Dear Mohamed Matope:

The purpose of this letter is to provide written confirmation of the authorization for private duty nursing services for [REDACTED] (the "Member") as prescribed by the attending physician, as follows:

- CareFirst BlueCross BlueShield, hereinafter referred to as "Corporation", has been advised that the Member shall begin receiving care from Community Care Nursing Services (Provider Name), hereinafter referred to as "Non-Par Provider", on June 8, 2024.

At this time and confirmed hereby, care has been authorized for in-network reimbursement under the Member's health benefit policy in effect for dates of service June 8, 2024 through September 8, 2024 or when Member has reached their maximum benefit level, whichever is earlier. Corporation and Non-Par Provider agree to an all-inclusive rate of Sixty dollars (\$60.00) per hour and which care/services shall include visits by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) for Twelve (12) hours of private duty nursing services per day, Sunday through Saturday for Three (3) months. Codes S9123 and S9124 only.

- HCPCS/CPT Code T1001 at an allowed amount of \$200.00 per visit (approved for 1 visit per month)
- Reimbursement payments will be made directly to Non-Par Provider. Non-Par Provider agrees to look solely to Corporation for payment of the reimbursement agreed upon and that the Member and all others will be held harmless from claims for any and all services rendered pursuant to this authorization, with the exception of
 - applicable Member liability such as coinsurance, copayments, deductibles and non-covered items or services; and
 - Payments made by Corporation to Member prior to the implementation of this Agreement.
- Provider understands and acknowledges this is a one-time agreement applicable only to this Member and does not establish a precedent for future participating provider negotiations with Corporation.
- To ensure accurate processing of claims, Non-Par Provider agrees to attach a copy of this letter to the claim(s) and submit the claim(s) to:

Christine Miller
CareFirst BlueCross BlueShield
Liaison, Claims, Large Group SBU/Mail Stop NAS-60
10 Commerce Drive
Cumberland, MD 21502

W- 301-777-6951 / F 410-505-2497
Email: Nonparclaimsprocessing@carefirst.com

AUDIT RIGHTS

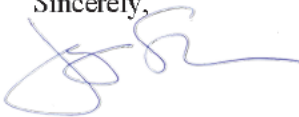
CareFirst shall have the right to audit any claims or payments, made pursuant to this agreement, and to effectuate its rights of recovery as stated below.

RIGHT OF RECOVERY

In the event that billings, made pursuant to the terms herein, result in overpayments or errant payments CareFirst shall have the right to recover such payments.

If this information does not accurately or adequately document the agreement regarding services for the Member, please contact Makia Dorrah Phone:410-872-3502. Otherwise, please sign where indicated below, and return a signed copy (via fax) to Makia's attention at 410-505-6978 as soon as possible.

Sincerely,



Jay Simmons,
VP Provider Networks Contracting

Provider Name

By: Mohamed Matope
(Signature)

Name: _____
(Print)

Title: _____

Date: _____

Federal Tax ID: _____

NPI: _____

December 3, 2025

VIA EMAIL ONLY

Quality One Care Home Health Inc.
Attn: Mohamed Matope
9221 Colesville Rd
Silver Spring, MD 20910
mmatope@qualityonecare.com

Dear Mr. Matope:

Subject: RFP No. 4290.5, Private Duty Nursing Services for Students with Special Needs

This letter is to inform you that the above referenced contract will expire on December 31, 2025. In accordance with the General Conditions, paragraph entitled Contract Term Montgomery County Public Schools (MCPS) would like to pursue the extension of this contract through June 30, 2026. **This will be the last possible extensions.**

Please indicate below your approval or disapproval and return the original to this office signed by an official authorized to enter into contracts with MCPS.

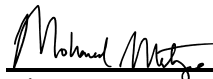
Your response is required via email to Saudy Espinal, Buyer II at saudy_espinaldeveloz@mcpsmd.org Once all responses are evaluated MCPS staff may make a recommendation to the Board of Education to extend the contract or decide to re-bid the contract. If the contract is extended, you will be notified after Board of Education action by a copy of a contract amendment.

In an effort to maintain the most accurate supplier records possible, please provide the most current company W9 as per publication released by the IRS (Rev. 10-2018). In addition, the Contractor Response Form is required each year and must be completed prior to providing services. Please email contractorobligation@mcpsmd.org for additional information.

It has been a pleasure doing business with you and we look forward to another successful year.


We/I agree to extend the contract

We/I do not wish to extend the contract


Signature

Director
Title

12/15/2025
Date

Sincerely,

Angela McIntosh-Davis, Director
Department of Procurement

AMD: se
Copy to: Bid File

MONTGOMERY COUNTY PUBLIC SCHOOLS

Expanding Opportunity and Unleashing Potential

DIVISION OF PROCUREMENT

240-740-7537

September 17, 2024

VIA EMAIL ONLY

Quality One Care Home Health, Inc.
Att: Mohamed Matope
9221 Colesville Rd
Silver Spring, MD 20910
mmatope@qualityonecare.com

Dear Mr. Matope:

Subject: RFP No. 4290.5, Private Duty Nursing Services for Students with Special Needs

This letter is to inform you that the above referenced contract term was **expired** on **06/30/2024**. In accordance with the General Conditions, paragraph entitled Contract Term; Montgomery County Public Schools (MCPS) would like to pursue a one-year extension of this contract. **Through 06/30/2025**. If there are any changes please submit with your response. This will be the second of three one-year option(s) to extend the contract.

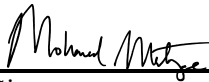
Please indicate below your approval or disapproval and return to this office signed by an official authorized to enter into contracts with MCPS. Your response is required within 10 days of receipt of this letter via email to saudy_espinaldeveloz@mcpsmd.org once your response is received and evaluated MCPS staff may make a recommendation to the Board of Education to extend the contract or decide to re-bid the contract. If the contract is approved by the Board of Education a contract amendment will be issued.

In an effort to maintain the most accurate supplier records possible, we require that you submit your company's most recent W9 with your response. In accordance with Maryland Law any person who enters into a contract with a county board of education "may not knowingly employ an individual to work at a school" if the individual is a registered sex offender. Criminal background checks, including fingerprinting, and identification badges are required as part of this process. Please follow the instructions under the following link.

<https://www.montgomeryschoolsmd.org/departments/procurement/contractors/>

We/I agree to extend the contract

We/I do not wish to extend the contract



Director

09/18/2024

Signature

Title

Date

Sincerely,



Angela McIntosh-Davis, CPPB, Director
Division of Procurement

AMD: SE

Copy to: Bid File

Purchasing Office
191 South East St.
Frederick, Maryland 21701
240-586-7502 phone
240-586-7501 fax



Bill Meekins CPPB, CPPO, NIGP-CPP, CSBO,
CPCP, Purchasing Manager
**Kim Miskell, CSBO, Assistant Purchasing
Manager**
Roy McHaffa, CPP, CPDW, Purchasing Agent
David Guzman, Purchasing Agent

August 13, 2024

Quality One Care Home Health, Inc.
9221 Colesville Road,
Silver Spring, MD 20910
Attn: Mohamed Matope, CEO
Email: msmatope@gmail.com

Ref: Contract Modification RFP 22MISC13, Contract Service Agencies for Private Duty Nursing

Dear Mr. Matope:

Please be advised Frederick County Public Schools is seeking an amendment to contract RFP 22MISC13, Contract Service Agencies for Private Duty Nursing to include the following requirement:

Page 34, Section II, 10. PROCEDURE FOR ORDERING SERVICES, BILLING AND PAYMENT PROCEDURES, #f. is being amended as follows:

- f. Firms shall invoice monthly and shall provide an itemized listing of work classification used in accordance with their Form of Proposal and Assignment Form. Only one month's billing should be included on each invoice; i.e., February and March nursing assignments should be on separate invoices. **Additionally, the Verification of Services Form must be completed, signed and submitted with monthly invoice(s). Incomplete or missing Verification of Services Form will delay the processing of the invoice(s).**

Your continued interest in serving the Frederick County Public Schools is appreciated. Should you have any questions concerning this matter, please contact me at (240) 586-7502.

Sincerely,

Kim Miskell

Kim Miskell, CSBO
Assistant Purchasing Manager

It is mutually agreed that the above referenced contract be amended for the remainder of the contract term (through June 30, 2026), with all other terms and conditions in the original contract unchanged.

Quality One Care Home Health, Inc.

Frederick County Public Schools:

Name: _____

Name: _____

Title: _____

Title: _____

Signature: Mohamed Matope

Signature: _____

Attachment

Purchasing Office
191 South East St
Frederick, Maryland 21701
301-644-5208 phone
301-644-5213 fax



Bill Meekins CPPB, CPPO, NIGP-CPP, CSBO,
CPCP, Purchasing Manager
**Kim Miskell, CSBO, Assistant Purchasing
Manager**
Roy McHaffa, CPP, CPDW, Purchasing Agent
David Guzman, Purchasing Agent

May 30, 2024

Quality One Care Home Health, Inc.
Mohamed Matope, CEO
9221 Colesville Road,
Silver Spring, MD 20910
msmatope@gmail.com

Ref: Notice of Renewal – RFP 22MISC13, Contract Agencies for Private Duty Nursing

Dear Mr. Matope:

Please be advised that on May 29, 2024, your company was part of a multi-vendor renewal by the Board of Education of Frederick County for RFP 22MISC13, Contract Agencies for Private Duty Nursing.

The renewal term will be effective from July 1, 2024 through June 30, 2026, with no renewal options remaining.

As stated in the specifications, please send the following documents within the next ten days:

- A current Certificate of Insurance in accordance with the coverage requirements listed in the bid document.

Your continued interest in serving the Frederick County Public Schools is appreciated. Should you have any questions concerning this matter, please contact me at (301) 644-5208 or kimberly.miskell@fcps.org.

Sincerely,

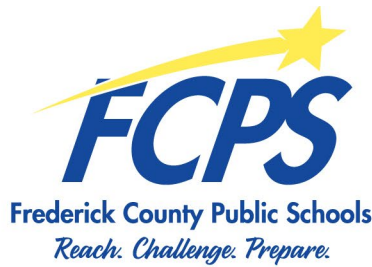
Kim Miskell

Kim Miskell
Assistant Purchasing Manager

KM/kl

cc: Jenifer Waters, Health Service Specialist
Bid File

Purchasing Office
191 South East St
Frederick, Maryland 21701
301-644-5208 phone
301-644-5213 fax



Bill Meekins CPPB, CPPO, NIGP-CPP,
CSBO, CPCP, Purchasing Manager
Kim Miskell, CSBO, Assistant Purchasing
Manager
Roy McHaffa, Purchasing Agent

July 19, 2022

Quality One Care Home Health, Inc.
Mohamed Matope, CEO
9221 Colesville Road,
Silver Spring, MD 20910
msmatope@gmail.com

Ref: Notice of Award – RFP 22MISC13, Contract Agencies for Private Duty Nursing

Dear Mr. Matope:

Please be advised that on July 13, 2022, your company was part of a multi-vendor award by the Board of Education of Frederick County for RFP 22MISC13, Contract Agencies for Private Duty Nursing.

The initial contract term shall be effective from date of award through June 30, 2024, with one two-year renewal term available.

As stated in the specifications, please send the following documents within the next ten days:

- A current Certificate of Insurance in accordance with the coverage requirements listed in the bid document.
- A current W-9.

Your continued interest in serving the Frederick County Public Schools is appreciated. Should you have any questions concerning this matter, please contact me at (301) 644-5208 or kimberly.miskell@fcps.org.

Sincerely,

Kim Miskell

Kim Miskell
Assistant Purchasing Manager

KM/kl

cc: Jenifer Waters, Health Service Specialist
Bid File

Cigna Healthcare
1640 Dallas Pkwy
Plano, TX 75093



Telephone: 800.244.6224
www.cignahealthcare.com

SINGLE CASE AGREEMENT

05/06/2025

Attn: Mohamed Matope
Quality One Care Health Inc
9221 Colesville Rd
Silver Spring, MD 20902
Tax ID: **900715209**
NPI: **1528351285**

RE: [REDACTED]
MEMBER ID#: [REDACTED]
AUTHORIZATION #: [REDACTED]
DATES OF SERVICE: 05/01/2025 – 12/31/2025

Dear **Quality One Care Health Inc,**

Per your discussion with **Gayla Martin**, you have agreed to accept the following rate of payment for certain health care services to be provided to [REDACTED]. As result, you are a Cigna participating provider with respect to such health care services provided to [REDACTED] and the agreed upon reimbursement rate for such health care services shall be considered for reimbursement at the in-network benefit level under member's Open Access Plus benefit plan.

Service(s)/Agreed upon rate:

Proc code / Modifiers	Unit Type: Hours	Billed Charge (per hour)	Total Billed Charge(s)	Allowed Amount (per hour)	Total Allowed Amount
S9123	960	\$80.00	\$76,800.00	\$68.00	\$65,280.00
S9124	combined	\$80.00		\$68.00	
Totals:			\$76,800.00		\$65,280.00

PLEASE FAX or E-MAIL TO: 855-890-0864 / ATTN: Gayla Martin, OR Gayla.Martin@CignaHealthcare.com

This Single Case Agreement (SCA) does not apply to any service other than those listed above. Any services other than those described herein must be authorized and a rate agreed upon in advance by Cigna in order to be considered at the in-network benefits level under the participant's benefit plan.

You shall accept as full and final payment for Services specified above, the lesser of billed charges or the reimbursement specified herein. This rate will be reduced by any applicable deductibles, copayments and/or coinsurance that You should collect from the participant and is subject to any applicable benefit plan limitations.

This SCA is based on the individual circumstances of the services for the claim underlying this SCA, and the parties agree that the rates agreed to in this SCA do not represent Cigna's view of fair market value, reasonable value, or the usual, customary, and reasonable rate for this claim or the types of services underlying the claim resolved through this SCA.

Payment pursuant to this SCA by Cigna (or other Payor, as applicable) will be subject to verification of the member's eligibility and coverage of the services according to the terms of the member's benefit plan at the time services are rendered. You may call member services number indicated on the member's identification card for more information. You will provide medical records as requested by Cigna pertaining to this service. Any deviation from the coding up to and including the procedure code, modifier, charge amount, and/or units negotiated will result in a delay in timely processing in accordance with this SCA.

You will abide by applicable federal and state laws and regulations including but not limited to the strict confidentiality of a Cigna member's identifiable information contained in any and all records regardless of medium utilized. You acknowledge that medical and other relevant information may be considered strictly confidential. You will not release, disclose, distribute and/or

otherwise disseminate or publish such member identifiable information received by you and report, if any, generated by you in a manner inconsistent with federal and state laws and regulations and only in accordance and related to the performance of your duties under this SCA.

You have agreed to accept this rate as payment in full for the service(s) described above and you will not seek payment from the participant or persons acting on the member's behalf for the services described in this Single Case Agreement or any additional services covered and authorized under the member's benefit plan. This provision shall not prohibit collection of applicable Copayments, Coinsurance or Deductibles in accordance with the terms of the member's benefit plan. You agree that this provision shall survive the termination of this SCA for described services and shall be construed in favor of the member. You agree that this provision supersedes any oral or written agreement now existing or hereafter entered into between you and Cigna with regard to this specific subject matter. You agree that you will never, under any circumstances, including Cigna's non-payment, insolvency, breach or termination of this SCA seek compensation from, have any recourse against or impose any additional charge on any eligible Cigna member for covered authorized services.

The relationship by and between Cigna and you established by this SCA is that of independent contractors and nothing contained in this SCA shall be construed to: a) constitute the parties as partners, joint ventures, co-owners or otherwise as participants in a joint or common undertaking; or b) allow either party to create or assume any obligation on behalf of the other party for any purpose whatsoever. All financial obligations associated with each party's business are the sole responsibility of that party. Employees and independent contractors of you will not be deemed to be employees of Cigna.

All claims arising under this SCA must be submitted within 90 days of the date of service or you will forego your right to collect for these services from any party, including the member.

You agree to cooperate with Cigna's medical management, discharge planning and quality assurance programs; with any Cigna dispute resolution and appeals process; and with any subrogation activities applicable to the member(s).

You agree to obtain and maintain during the effective period hereof, a policy or policies of professional malpractice insurance insuring you and your employees against any and all liabilities or claims for damages arising from or relating to personal injury or death occasioned directly or indirectly in connection with the performance of the services rendered by you and under this SCA. You shall maintain adequate professional liability insurance coverage. You shall notify Cigna immediately of any and all changes in or cancellation of insurance coverage during the term of this SCA.

Neither party shall transfer or assign directly or indirectly by operation of law or otherwise, this SCA or its rights and obligations hereunder without the prior written consent of the other party. Subject to the foregoing, this SCA shall be binding upon and inure to the benefit of the parties and their successors and assigns.

If all or part of any term or provision hereof is illegal or invalid for any reason whatsoever, the validity of the remaining provisions will not be affected, provided that the expected economic benefits of such remaining provisions shall not be denied to either party.

This SCA is effective on the date it is signed by both parties and may be modified or terminated only by written agreement signed by both parties.

Thank you for this opportunity to be of service to Cigna's member(s).

Cigna Healthcare
1640 Dallas Pkwy
Plano, TX 75093

Quality One Care Health Inc
9221 Colesville Rd
Silver Spring, MD 20902

Christina Hayward
Christina Hayward
AVP, National Contracting &
Nonpar Network Management
Cigna Healthcare

SIGNATURE *Mohamed Matope*

PRINT NAME **MOHAMED MATOPE**

PRINT TITLE **DIRECTOR**

05/07/2025
Date

05/06/2025
Date

"Cigna Healthcare" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

*Your insurer or claim administrator has arranged with Cigna Health Management, Inc. and Cigna Behavioral Health, Inc. (if applicable) to provide utilization review and/or case management services.



August 14, 2024

Elizabeth M Luanda
Chief Executive Officer
Quality One Care Home Health, Inc.
9221 Coleville Road
Silver Spring, MD 20910

Joint Commission ID #: 519232
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards
Compliance
Accreditation Activity Completed: 8/8/2024

Dear Ms. Luanda:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual noted below:

Comprehensive Accreditation Manual for Home Care

This accreditation cycle is effective beginning June 8, 2024, and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on the Find Accredited Organizations page of our website.

Congratulations on your achievement.

Sincerely,

A handwritten signature in black ink, appearing to read "Ken Grubbs".

Ken Grubbs, DNP, MBA, RN
Executive Vice President and Chief Nursing Officer
Division of Accreditation and Certification Operations

HIGH QUALITY CARE, INC

"Bringing Quality Care To you"

217 Main Street, Suite 201, Laurel, MD 20707 Ph 301-617-9315 Cell 301-617-9319



December 20, 2025

Maryland Health Care Commission
ATTN: Certificate of Need Review

RE: Letter of Support / Referral Partnership for Quality One Care Home Health, Inc. Proposed Home Health Agency (HHA) Service Area (Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties)

To Whom It May Concern:

On behalf of High Quality Care, Inc., I am writing to express strong support for Quality One Care Home Health, Inc. ("Quality One Care" or "QOC") in connection with its Certificate of Need application to establish and operate a Medicare-certified Home Health Agency (HHA) serving Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties in Maryland.

I have had the opportunity to work closely with Quality One Care for over ten (10) years through professional collaboration and subcontracted service arrangements. Throughout this time, QOC has consistently demonstrated excellence in clinical practice, documentation standards, and patient-centered service delivery. QOC has earned a strong reputation for recruiting highly skilled nursing staff and maintaining a dependable operational structure that supports continuity of care.

High Quality Care regularly encounters individuals and families who require skilled home health services. Upon approval and launch of QOC's proposed HHA, we anticipate coordinating and referring appropriate patients to QOC for home health services, including skilled nursing, therapy services, and care coordination as clinically indicated. We are confident QOC will provide safe, timely, and compliant care that supports improved outcomes and reduced avoidable hospital utilization.

Based on our long-standing working relationship, we believe Quality One Care has the qualifications, staffing capacity, and operational readiness to successfully operate a Medicare-certified home health agency and to serve as a trusted partner in the continuum of care.

Please feel free to contact me if additional information would be helpful.

Sincerely,

Dr Joy Davis

3602 BALIN CT.
ANNANDALE, VA 22003
TEL (703)479-8716/301-523-6233
FAX (800)878-9505
INFO@NUDIMENSIONSLLC.COM
WWW.NUDIMENSIONSLLC.COM



NUDIMENSIONS

Excellent Care Begins and Ends Here

December 18th, 2025

To Whom it may concern

Nu Dimensions LLC is writing to confirm our professional relationship with Quality One Care Home Health, Inc. (“Quality One Care” or “QOC”) and to express support for QOC’s Certificate of Need application to establish and operate a Medicare-certified Home Health Agency (HHA) serving Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties.

For several years, Nu Dimensions has worked with QOC to support clinical services and care coordination for individuals in our group home settings. QOC has provided consistent clinical support, reliable nursing services, strong documentation practices, and quality oversight.

Upon approval of QOC’s proposed HHA, Nu Dimensions anticipates coordinating and referring appropriate patients to QOC for skilled home health services as clinically indicated.

Please contact me if additional information would be helpful.

Sincerely,

Martin Tamukong

CEO





Achieve with us.

Dec 18, 2025

To Whom It May Concern:

As a healthcare facility with many patients and varying degrees of complex care situations, we have had to work with other healthcare agencies in the area in order to us to fulfill our goals in providing excellent health care services to the community and our patients. One of such agencies is Quality One Care.

Our partnership with Quality One Care started in 2018 and they have been a very valuable partner to us not only in the home health care services but also as a consultant on some of our cases. Since our partnership, we have come to appreciate their high level of initiative, strong work ethics and proven leadership in their services as well as expertise in home care management. The level of caregiver experience, healthcare assessment skills and competency in the code of conduct that their staff brings to the table is refreshing when compared to other agencies we have partnered with in the past. Their administrative staff is well versed, professional and well trained when it comes to handling difficult situations that sometimes arise in the field. Their expertise and experience in risk-management and their dedication to provide quality services to our clients has been one of the reasons why we put at the top of our partners in the region. We appreciate a partner that can not only do their duties, but also understands our goals as a company and aims to help us achieve those goals.

Quality One Care has been an exceptional partner and we frequently recommend their services and expertise to our clients and patients.

Sincerely,

A handwritten signature in black ink that reads "Ericka W. Abrah-Oyedot".

1401 McCormick Drive
Largo, Maryland 20774

T 301-925-7050 F 301-925-4387
www.thearcofpgc.org

EXHIBIT 14

RSA Licensure & Accreditation

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

CONTENTS
RSA State Licenses
The Joint Commission Accreditation (JCAHO)
JCAHO Survey Results
Insurance Certification...



DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

April 14, 2023

Quality One Care Home Health, Inc.
Mohamad Matope, Director
9221 Colesville Road
Silver Spring, MD 20910

Dear Mr. Matope,

This is to acknowledge the receipt and approval of a change of address for your agency, and an updated license as a Health Care Staff Agency.

The enclosed license is non-expiring, unless revoked. It is your authority to operate a Health Care Staff Agency under the Maryland Department of Health, Code of Maryland Regulations (COMAR) 10.07.03.

This State license is to be displayed in a conspicuous place, at or near the entrance of your office, plainly visible and easily read by the public. If questions arise, please contact our Office by calling (410) 402-8094.

Sincerely,

Glenda Roberts, Administrative Officer III
Developmental Disabilities/Allied Health Unit
Office of Health Care Quality

Enclosure: Non-expiring License



STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY
7120 SAMUEL MORSE DRIVE
SECOND FLOOR
COLUMBIA, MARYLAND 21046

License No.: HCS800389

Issued to: Quality One Home Health Care, Inc.
9221 Colesville Road
Silver Spring, MD 20910

Type of License Issued:
HEALTH CARE STAFF AGENCY

Date Issued: April 14, 2023

Expiration: **NON-EXPIRING**

Provides In:

HEALTH CARE STAFF FACILITIES

This license is granted pursuant to the Health-General Article, Title 19, Subtitle 20, Annotated Code of Maryland, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Patricia Tomello May, MD

Executive Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.



EXH # 10

**STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY
7120 SAMUEL MORSE DRIVE
SECOND FLOOR
COLUMBIA, MARYLAND 21046-3422**

License No: R3057R

Issued to: Quality One Care Home Health Inc
9221 Colesville Road
Silver Spring, MD 20910

Type of Agency: RESIDENTIAL SERVICE AGENCY

Date Issued: July 1, 2018

Service(s) Provided: Skilled Nursing and Aides; Level Three; Complex Care Provided by a Registered Nurse (RN)/Licensed Practical Nurse and RN Supervision of Aides

Population: Adults and Pediatrics

Other: REPLACEMENT LICENSE; CHANGE OF ADDRESS

Authority to operate in this State is granted to the above entity pursuant to the Health-General Article, Section 19-4A et Seq., Annotated Code of Maryland and is subject to any and all statutory provisions including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration: NON-EXPIRING

Patricia Tomasko May, MD

Executive Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.



STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No: R3057

Issued to: Quality One Care Home Health Inc
d/b/a Quality One Care Home Health, Inc
12510 Prosperity Drive Suite 320
Silver Spring, MD 20904

Type of Facility or Community Program:
RESIDENTIAL SERVICE AGENCY

Date Issued: July 1, 2018

Service(s) Provided: Skilled Nursing and Aides; Level of Care: Complex Care Provided by
RN/LPN and RN Supervision of Aides

Other: N/A

Authority to operate in this State is granted to the above entity pursuant to the Health-General Article, Section 19-4A et Seq., Annotated Code of Maryland and is subject to any and all statutory provisions including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration: **NON-EXPIRING**

Patricia Tomoko May, MD

Executive Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

July 9, 2012

Ms. Elizabeth Puryear
Quality One Care Home Health Inc
10318 Castle Hedge Terrace
Silver Spring, MD 20902

Dear Ms. Puryear:

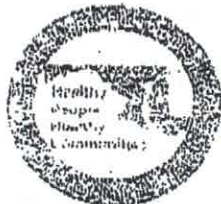
Your application as a Medical Assistance Provider for the Home and Community Based Services Waiver for Older Adults has been received and reviewed by representatives of the Maryland Department of Aging (MDoA) and the Medical Assistance Program at the Department of Health and Mental Hygiene.

You have been approved to provide for the following waiver services and procedure codes effective **June 19, 2012**:

1. Personal Care – Agency PC Aide without Medication Administration
– Procedure Code – W0202
2. Personal Care – Agency PC with Medication Administration
– Procedure Code – W0203
3. Personal Care Nurse Monitoring – Procedure Code W0204
4. Personal Care Agency Respite Care – Procedure Code W0206

The provider number assigned to you is **5209013-00**. This provider number is assigned the specific procedure codes that allow you to bill for only the services for which you have been approved. This provider number cannot be interchanged with any other provider number (s) that you may have. MDoA will also receive a copy of your provider number. Your NPI# (National Provider Identification) # is: **55209013-00** **some correspondence may request this number**. No bills for waiver services will be paid for dates of service prior to the above effective date.

Enclosed is your new provider number, information about the waiver program, including the governing regulations, waiver transmittals, reportable event policy procedure information and billing instructions. **Billing claims should be submitted to the following address, unless you are otherwise notified by your local Department of Aging:**



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

September 6, 2013

Mr. Mohamed Matope, R.N.
Quality One Care Home Health, Inc.
10318 Castle Hedge Terrace
Silver Spring, MD 20902

RE: Provider Enrollment
Residential Service Agency (RSA)
Provider Type 53
Provider #: 420641000 (Approved)

Dear Mr. Matope:

The Division of Nursing Services (DONS) has approved Quality One Care Home Health, Inc.'s ("Quality One") request to enroll as a provider in the EPSDT: Private Duty Nursing (PDN) Program. Provider Enrollment will be notified to approve Quality One's provider number.

In an effort to improve our training sessions, the DONS' has enclosed a Provider Feedback Form. Please review this form and answer the questions and comments as you see fit. This form should be submitted to my attention no later than Friday, October 4, 2013.

Department of Health & Mental Hygiene
Division of Nursing Services
201 W. Preston Street, Room
Baltimore, MD 21201

Please keep in mind to include all of Quality One's policy revisions in your manuals. This will assist your agency when being audited at a later date.

Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.maryland.gov



1100 Virginia Drive, Suite 250
Fort Washington, PA 19034-3278
Phone:1-888-288-3534 Fax:1-847-953-0134
Website:www.nso.com

12/06/24

Quality One Care Home Health Inc.
9221 Colesville Rd
Silver Spring, MD 20910-1657

Dear Mohamed Matope:

Enclosed is the replacement certificate of insurance that you requested.

If you have any questions or need assistance, please call us toll free at 1-888-288-3534 . Our Customer Service Representatives are available weekdays from 8:00 a.m. to 6:00 p.m., EST.

Sincerely,

Customer Service

Enclosure

Dedicated To Serving The Insurance Needs of Nurses
Nurses Service Organization is a registered trade name of Affinity Insurance Services, Inc.; (AR 244489); in CA & MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services Inc.; in CA, Aon Affinity Insurance Services, Inc., (0G94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY, AIS Affinity Insurance Agency.

Q032



HEALTHCARE PROVIDERS SERVICE
ORGANIZATION PURCHASING GROUP



Certificate of Insurance
OCCURRENCE PROFESSIONAL LIABILITY POLICY FORM

Print Date: 12/06/2024

The application for the Policy and any and all supplementary information, materials, and statements submitted therewith shall be maintained on file by us or our Program Administrator and will be deemed attached to and incorporated into the Policy as if physically attached.

PRODUCER 018098	BRANCH 970	PREFIX HPG	POLICY NUMBER 0615736333	POLICY PERIOD From: 12/06/24 to 12/06/25 at 12:01 AM Standard Time
Named Insured and Address: Quality One Care Home Health Inc. 9221 Colesville Rd Silver Spring, MD 20910-1657			Program Administered by: Nurses Service Organization 1100 Virginia Drive, Suite 250 Fort Washington, PA 19034 1-888-288-3534 www.nso.com	
Medical Specialty: Nursing Firm		Code: 80964		Insurance Provided by: American Casualty Company of Reading, Pennsylvania 151 N. Franklin Street Chicago, IL 60606
Excludes Cosmetic Procedures				

Professional Liability \$ 1,000,000 each claim \$ 6,000,000 aggregate

Your professional liability limits shown above include the following:

- * Good Samaritan Liability
- * Malplacement Liability
- * Personal Injury Liability
- * Sexual Misconduct Included in the PL limit shown above subject to \$ 25,000 aggregate sublimit

Coverage Extensions

License Protection	\$ 25,000	per proceeding	\$ 25,000	aggregate
Defendant Expense Benefit	\$ 1,000	per day limit	\$ 25,000	aggregate
Deposition Representation	\$ 10,000	per deposition	\$ 10,000	aggregate
Assault	\$ 25,000	per incident	\$ 25,000	aggregate
Includes Workplace Violence Counseling				
Medical Payments	\$ 25,000	per person	\$ 100,000	aggregate
First Aid	\$ 10,000	per incident	\$ 10,000	aggregate
Damage to the Property of Others	\$ 10,000	per incident	\$ 10,000	aggregate
Enterprise Privacy Protection - Claims Made	\$ 25,000	per incident	\$ 25,000	aggregate
Retroactive Date: 12/06/2015(Defense inside limits)				
Media Expense	\$ 25,000	per incident	\$ 25,000	aggregate
Employment Practices Liability - Claims Made	\$ 25,000	per incident	\$ 25,000	aggregate
Retroactive Date: 12/06/2019(Defense Only)				

General Liability

General Liability	\$1,000,000 each claim / \$6,000,000 aggregate
Fire & Water Legal Liability	Included in the GL limit shown above subject to \$250,000 aggregate sublimit
Personal Liability	Excluded

Total \$ 5,972.00

Base Premium \$5,972.00

Policy Forms and Endorsements (Please see attached list of policy forms and endorsements)

Chairman of the Board

Secretary

Keep this Certificate of Insurance in a safe place. It and proof of payment are your proof of coverage. There is no coverage in force unless the premium is paid in full. To activate your coverage, please remit premium in full by the effective date of this Certificate of Insurance.

Coverage Change Date:

Endorsement Date:

Master Policy: 188711433

CNA93692 (11-2018)

POLICY FORMS & ENDORSEMENTS

The following are the policy forms and endorsements that apply to your current professional liability policy.

COMMON POLICY FORMS & ENDORSEMENTS

FORM #	FORM NAME
G-121500-D (04-08)	Common Policy Conditions
G-121501-C (07-01)	Occurrence Policy Form
CNA82011 (04-15)	Related Claims Endorsement
G-145184-A (06-03)	Policyholder Notice - OFAC Compliance Notice
G-147292-A (03-04)	Policyholder Notice - Silica, Mold & Asbestos Disclosure
CNA81753 (03-15)	Coverage & Cap on Losses from Certified Acts Terrorism
CNA81758MD (01-21)	Notice - Offer of Terrorism Coverage & Disclosure of Premium
GSL13424 (05-09)	Services to Animals
GSL13425 (05-09)	Business Owner Coverage Extension Endorsement
GSL15564 (10-09)	Sexual Misconduct Sublimits of Liability Professional Liability & Sexual Misconduct Exclusion
GSL15565 (03-10)	Healthcare Providers Professional Liability Assault Coverage
GSL17101 (02-10)	Exclusion of Specified Activities Reuse of Parenteral Devices and Supplies
CNA80052 (09-14)	Distribution or Recording of Material or Information in Violation of Law Exclusion Endorsement
CNA94164 (11-18)	Amendment Definition of Claim Endorsement
CNA79802MD (08-14)	Maryland Policyholder Notice
G-123846-C19 (01-02)	Maryland Cancellation and Non-Renewal
CNA79516MD (11-14)	Enterprise Privacy Protection
CNA79575 (07-14)	Exclusion of Cosmetic Procedures
CNA89026 (05-17)	Media Expense Coverage
CNA93658 (08-18)	Employment Practices Liability Coverage - Defense Only
G-121504-C (07-01)	General Liability Form
G-123827-B (07-01)	Additional Insured General Liability
G-123828-B (07-01)(04)	Certificate Holder
GSL13428 (05-09)	DBA or Specified Endorsements

PLEASE REFER TO YOUR CERTIFICATE OF INSURANCE FOR THE POLICY FORMS & ENDORSEMENTS SPECIFIC TO YOUR STATE AND YOUR POLICY PERIOD.

For NJ residents: The PLIGA surcharge shown on the Certificate of Insurance is the NJ Property & Liability Insurance Guaranty Association.

For KY residents: The Surcharge shown on the Certificate of Insurance is the KY Firefighters and Law Enforcement Foundation Program Fund and the Local Tax is the KY Local Government Premium Tax. As required by 806 Ky. Admin Regs. 2:100, this Notice is to advise you that a surcharge has been applied to your insurance premium and is separately itemized on the Declarations page or billing instrument attached to your policy, as required KRS. §136.392.

For WV residents: The surcharge shown on the Certificate of Insurance is the WV Premium Surcharge.

For FL residents:

Form #: CNA93692 (11-2018)

Named Insured: Quality One Care Home Health Inc.

Master Policy #: 188711433

Policy #: 0615736333

Quality One Care Home Health, Inc.

Silver Spring, MD

has been Accredited by

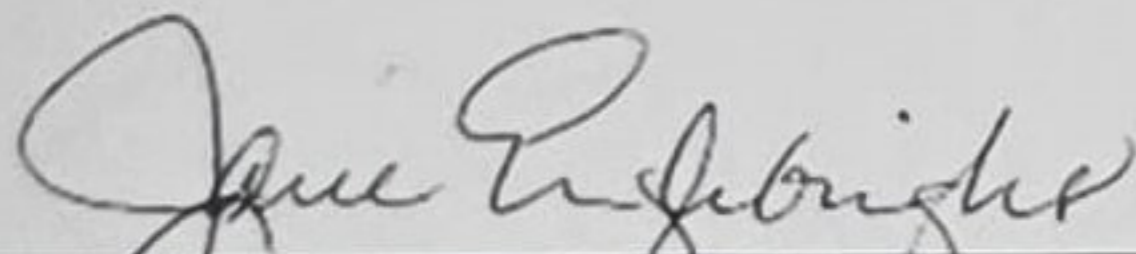


The Joint Commission

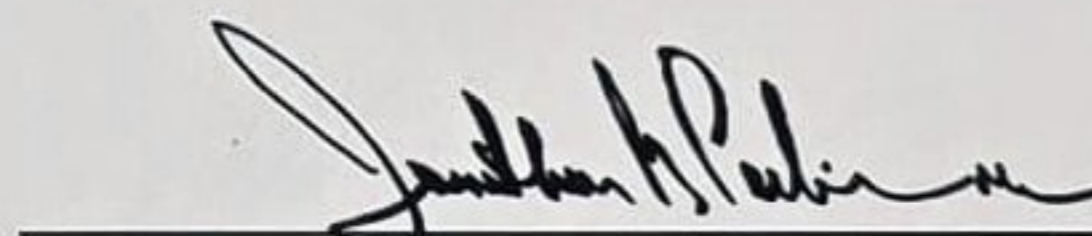
Which has surveyed this organization and found it to meet the requirements for the
Home Care Accreditation Program

June 8, 2024

Accreditation is customarily valid for up to 36 months.


Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #519232
Print/Reprint Date: 08/15/2024


Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



EXH # 1C



July 13, 2021

Elizabeth M Luanda, CEO
Quality One Care Home Health, Inc.
9221 Codeville Rd.
Silver Spring, MD 20910

Joint Commission ID #: 519232
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards
Compliance
Accreditation Activity Completed : 7/9/2021

Dear Ms. Luanda:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Home Care

This accreditation cycle is effective beginning June 26, 2021 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

A handwritten signature in cursive script that reads "Mark Pelletier".

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

Quality One Care Home Health, Inc.

Silver Spring, MD

has been Accredited by

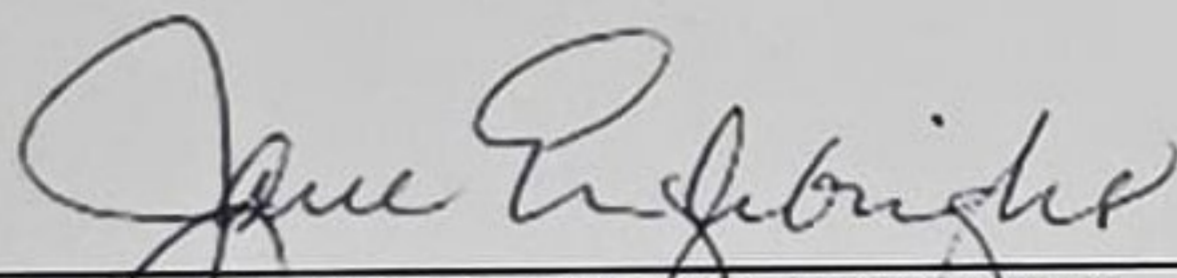


The Joint Commission


Which has surveyed this organization and found it to meet the requirements for the
Home Care Accreditation Program

June 26, 2021

Accreditation is customarily valid for up to 36 months.


Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #519232
Print/Reprint Date: 07/14/2021


Mark R. Chassin, MD, FACP, MPP, MPH
President

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Documentation of RSA* Applicant’s Qualifications to Establish a Home Health Agency in Maryland
*Maryland Residential Service Agency Providing Skilled Nursing Services

Applicant: Quality One Care Home Health, Inc

Maryland RSA license #: R3057R

1. PERFORMANCE-RELATED QUALIFICATIONS: COMAR 10.24.16.06.D and 10.24.16.07 outline performance-related qualifications that an applicant must meet in order for the MHCC to accept a CON application to establish a home health agency (HHA). The performance-related qualifications vary by type of applicant. MHCC staff has developed guidelines for all types of applicants, including a Maryland residential service agency (RSA) providing skilled nursing services, to assist staff in determining whether a potential applicant meets performance-related requirements. An RSA applicant should refer to the Guideline document, which can be found on the Commission’s website at: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_homehealth/documents/chcf_review_guidance_stds.pdf

2. DATA SUBMISSION REQUIREMENTS: An RSA applicant may qualify to apply for a CON to establish an HHA in Maryland by demonstrating a track record of providing good quality care. An RSA applicant must submit data to the MHCC to document the ability to monitor the required quality measures and performance levels outlined in Appendix E of the Guidelines:

- Documentation of the RSA’s status as accredited for the three most recent years of operation through a deeming authority recognized by Maryland’s Department of Health and Mental Hygiene.
- Documentation that the RSA has provided skilled nursing services, including the specific types and utilization of skilled nursing services provided during the most recent three years of operation (**complete Table 1**; refer to Sample Worksheet E1 in Guidelines document).
- A brief description of the RSA’s quality assurance program, to include identification of the quality measures monitored by the RSA that are comparable to those measures submitted by HHAs to CMS (for example, if your RSA uses a client survey, submit a copy of the survey); and
- Examples of specific quality measures tracked, and performance levels achieved during the most recent three years of operation (**complete Table 2**; refer to Sample Worksheet E2 in Guidelines document).

3. QUALIFICATIONS FOR ALL APPLICANTS: COMAR 10.24.16.06C provides that the MHCC will only accept a CON application from an applicant that documents the characteristics and requirements listed immediately below. An applicant must indicate whether each statement on the left side of the grid below is true or false (or not applicable), and separately provide documentation as indicated.



June 25, 2018

Elizabeth M Luanda
CEO
Quality One Care Home Health, Inc.
12510 Prosperity Dr., Suite 320
Silver Spring , MD 20904

Joint Commission ID #: 519232
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards
Compliance
Accreditation Activity Completed : 6/25/2018

Dear Ms. Luanda:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Home Care**

This accreditation cycle is effective beginning June 23, 2018 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

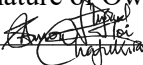
Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

Documentation of Qualification

RSA Applicant

Page 2

The Applicant:	Write response (true, false, or not applicable)
(1) Has not had its Medicare or Medicaid payments suspended within the last five years;	True
(2) Has not been convicted of Medicare or Medicaid fraud or abuse within the last ten years;	True
(3) Has received at least satisfactory findings reflecting no serious adverse citations on the most recent two survey cycles from its respective state agency, accreditation organization, or both, as applicable to the type of applicant;	True See JCAHO Accreditation Exhibits
(4) Has maintained accreditation through a state-recognized deeming authority, as applicable, for at least the three most recent years;	True See JCAHO Accreditation Exhibits
(5) Has submitted an acceptable plan of correction for any valid and serious patient-related complaint investigated over the past three years;	True See JCAHO Corrective Actions Exhibit
(6) Has complied with all applicable federal and State quality of care reporting requirements and performance standards;	True See Quality Measures Exhibit
(7) Documents availability of sufficient financial resources to implement the proposed project within the applicable timeframes set forth in the Commission’s performance requirements at COMAR 10.24.01.12; 10.24.16;	See Financial Resources Exhibit
(8) Demonstrates a record of serving all applicable payer types, such as Medicare, Medicaid, private insurance, HMOs, and self-pay patients; and	See Payor Mix
(9) Affirms under penalties of perjury, that within the last ten years, no owner or senior management, or owner or senior management of any related or affiliated entity, has been convicted of a felony or crime or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony or crime.	True
<p>ATTESTATION:</p> <p>I, the undersigned, am an owner, or authorized agent of the applicant that has filed a letter of intent to establish or expand a home health agency in Maryland. I hereby affirm under the penalties of perjury that the information in this Documentation of Qualifications and attached tables is true and correct to the best of my knowledge, information, and belief.</p> <p>Signature of Owner or Authorized Agent of the Potential Applicant:  _____</p> <p>Name and Title: <u>AMON CHAFUKIRA - Program Coordinator</u></p> <p>Date: <u>08/15/2025</u></p>	

Quality One Care Home Health, Inc.

Silver Spring, MD

has been Accredited by

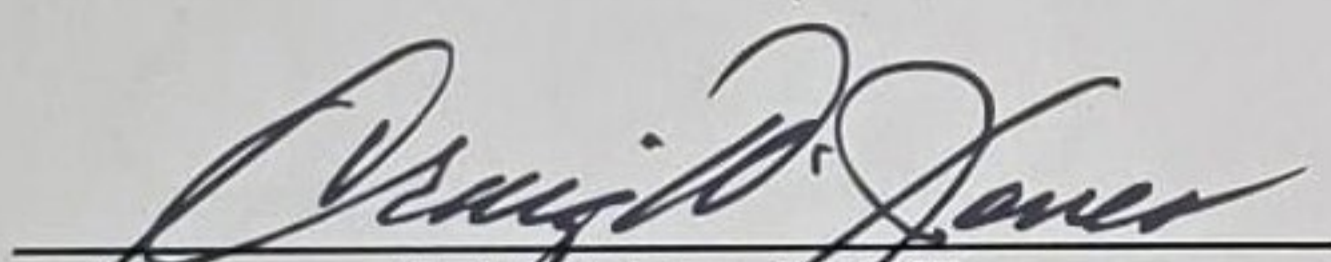


The Joint Commission

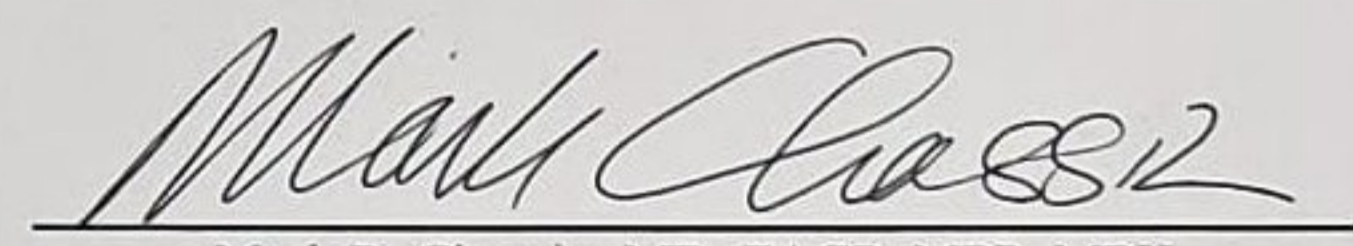
Which has surveyed this organization and found it to meet the requirements for the
Home Care Accreditation Program

June 25, 2018

Accreditation is customarily valid for up to 36 months.


Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #519232
Print/Reprint Date: 06/26/2018


Mark R. Chassin, MD, FACP, MPP, MPH
President

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*Provide Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. – See Exhibit 6

Table 1: RSA Skilled Nursing Services Provided and Number of RSA Clients Served

Skilled Nursing Services Provided to RSA Clients*	CMS-Aligned Service Category	Number of RSA Clients with Skilled Nursing Services by Year			% Change 2023 vs 2022
		2023	2022	2021	
Tracheostomy Care	Respiratory Support	58	40	42	45.0%
Ventilator Care	Respiratory Support	16	9	22	77.8%
Tube Feeding Care	Nutritional Support	78	61	54	27.9%
Ostomy Care	Digestive & Excretory Support	4	3	1	33.3%
Urinary Catheter Care	Digestive & Excretory Support	8	3	2	166.7%
Medication Administration	Medication Management	78	63	57	23.8%
Wound care	Wound Management	4	6	8	-33.3%
Cardiac Care	Cardiovascular Support	3	2	4	50.0%
Post-Operative Care	Post-Surgical Care	4	7	9	-42.9%
IV Infusion	Infusion Therapy	4	6	7	-33.3%
TOTAL number of patients receiving skilled nursing services*		76	68	64	11.8%
% Change from Previous Year		+11.8%	+6.3%	-	-
Number of RSA Clients not receiving skilled nursing services**		3	2	6	50%

Table Summary

The data in Table 1 clearly demonstrates the consistent growth and increasing demand for our services, with the total number of skilled nursing clients rising from 64 in 2021 to 76 in 2023. This upward trend, including a notable 11.8% increase from 2022 to 2023, highlights our ability to effectively expand our reach and meet the needs of the community. The numbers also reflect our agency's growing specialization in complex care.

The significant increase in clients for both Tracheostomy Care and Tube Feeding Care shows that we are addressing a vital need for high-acuity services in our service area. Furthermore, the consistently low number of clients who do not receive skilled nursing services confirms that we are maintaining a strong focus on our core business and expertise.



Final Accreditation Report

**Quality One Care Home Health, Inc.
9221 Coleville Rd.
Silver Spring, MD 20910**

**Organization Identification Number: 519232
Unannounced Full Event: 6/7/2024 - 6/7/2024**

**Program Surveyed
Home Care**

Quality One Care Quality Assurance Program Description

Quality One Care Home Health, Inc. operates a robust Quality Assurance and Performance Improvement (QAPI) program that we've carefully designed to align with both Maryland Residential Service Agency (RSA) guidelines and the quality standards of a Home Health Agency (HHA) as set by CMS. Our program's main objective is to continuously monitor and enhance the quality, safety, and client satisfaction of our home care services.

We have a systematic approach to quality assurance that includes actively tracking a number of key measures. These measures are specifically chosen to be comparable to those submitted by HHAs to CMS, and they give us clear data on how we are performing.

1. Key Quality Measures

Quality One Care routinely monitors a number of quality measures to make sure that our services are in compliant with CMS's HHA outcome and Process Measures. These measures include:

- Tracheostomy Suctioning Technique Compliance (Client/Family Demonstration)
- Feeding Tube Insertion Accuracy (Client/Family Demonstration)
- Hand Hygiene Compliance (Client/Family)
- Home Equipment Maintenance and Cleaning Compliance (Staff Audit)
- Home Oxygen Safety Training Completion Rate (Client/Family)
- Fall Reduction Education Completion Rate (Client)
- Safe Medication Administration Education (Client)
- Hazard Vulnerability Assessment Completion (Client)
- Overall Customer Satisfaction: "Needs Met by Staff"

As reflected in our performance tables, we track each measure annually. We're proud that many of our measures show consistent performance or improvement over the last three years, with a majority achieving 95% or higher compliance. This data helps us confirm that our efforts are making a real difference in the lives of our clients.

2. Tools and Documentation

To support our program, we rely on a variety of tools and documentation. We conduct annual client satisfaction and skills demonstration surveys that mirror CMS-aligned instruments, including Likert-style and checkboxes which uses a combination of qualitative and quantitative questions to gather valuable and impactful feedback. We also perform structured staff audits and maintain meticulous education logs to ensure our processes and training are effective.

3. Performance Tracking

We track our performance using internal dashboards that are reviewed monthly, with comprehensive trend analysis conducted at our quarterly quality review meetings. This proactive approach allows us to quickly identify any potential deficiencies and implement corrective action plans. These plans often include staff retraining, updated procedures, or re-education for our clients and their families, ensuring our services are always improving.

The Joint Commission

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<u>Appendix</u>	7
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• Report Section Descriptions	9
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Table 2. Quality Measures by Measure Type and Performance Level achieved

Type of Quality Measure	Measure Type	Performance Level Achieved		
		2023	2022	2021
Tracheostomy Suctioning Technique Compliance (Client/Family Demonstrated)	Outcome (CMS QM)	98%	99%	99%
Feeding Tube Insertion Demonstration (Client/Family Accuracy)	Outcome	98%	97%	99%
Hand Hygiene Compliance (Client/Family)	Outcome (CMS QM)	90%	80%	85%
Home Equipment Maintenance/Cleaning Compliance (Staff Audit)	Outcome	95%	95%	98%
Home Oxygen Safety Training Completion Rate (Clients/Family)	Process	100%	100%	100%
Fall Reduction Education Completion Rate (Clients)	Process (CMS QM)	100%	100%	100%
Safe Medication Administration Education (Clients)	Process	100%	100%	97%
Hazard Vulnerability Assessment Completion (Clients)	Process	95%	87%	78%
Overall Customer Satisfaction — “Needs Met by Staff” (Annual Survey Result)	Experience of Care	98%	98%	97%

Notes:

- All quality metrics above were monitored continuously and reviewed quarterly by the agency’s Quality Assurance & Performance Improvement (QAPI) Committee.
- Outcome data was collected via RN supervisory audits, in-home demonstrations, and compliance checklists. Experience of care data was obtained through annual client satisfaction surveys.
- “**CMS QM**” marks metrics that are aligned with measures that are also tracked by the Centers for Medicare & Medicaid Services
- **Hand Hygiene Compliance:** The improvement in 2023 was a direct result of our "Clean Hands Matter" training initiative launched in Q4 of 2022.
- **Hazard Vulnerability Assessment:** Our year-over-year improvement reflects a strengthened internal process to ensure all clients receive a comprehensive assessment.

The Joint Commission

Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	06/07/2024 - 06/07/2024	Requirements for Improvement	Clarification (Optional) Evidence of Standards Compliance (ESC)	Submit within 10 Business Days from the final posted report date Submit within 60 Calendar Days from the final posted report date

Table 3. Current QOC RSA Client Payor Mix

Payor	Percentage
Medicare	0%
Medicare Advantage	0%
Medicaid	90%
Medicaid MCO	1% (Includes University of Maryland Health Partners)
Blue Cross	1% (Includes BlueCross BlueShield)
Other Commercial Insurance	7% (Physicians Health – 3.5%, CareFirst – 1.5%, Cigna – 1%)
Self-Pay (Private Pay)	1%
Other (Specify)	1% (County Public School System: MCPS, CCPS, FCPS)
Total	100%

The Joint Commission

What's Next - Follow-up Activity

Program: Home Care

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
RC.02.01.01	2	Moderate / Widespread	✓

The Joint Commission SAFER™ Matrix

Program: Home Care

Likelihood to harm a Patient / Visitor / Staff		Scope		
ITHS	High	Moderate	Low	
		RC.02.01.01 EP 2		Widespread
				Pattern
				Limited

The Joint Commission Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation
RC.02.01.01	2	Moderate Widespread	<p>The patient record contains the following clinical information:</p> <ul style="list-style-type: none"> - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. <p>Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.</p> <p>Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)</p>	<p>1) Observed in Record Review at Quality One Care Home Health, Inc. (9221 Coleville Rd., Silver Spring, MD) site . In 4 of 4 patient records reviewed, the surveyor noted the medical record was missing documentation regarding the treatment the nurses were providing. For Example HV#1,2 RR#1 and 2 the nurses would document care was provided and nurse had not documented what type of care was provided. For example G-tube care provided and there was no documentation of the care was. Confirmed by the DON</p>

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP & Addendum Text
RC.02.01.01	2	The patient record contains information that reflects the patient's care, treatment, or services.	<p>The patient record contains the following clinical information:</p> <ul style="list-style-type: none"> - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. <p>Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.</p> <p>Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care</p>

The Joint Commission

Standard	EP	Standard Text	EP & Addendum Text
			and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	<ul style="list-style-type: none"> Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	<ul style="list-style-type: none"> ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannounced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey

Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors

Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored “not compliant” at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey**. (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.
- The organization has detailed evidence that was not immediately available **at the time of the survey**. The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.
- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.



Final Accreditation Report

**Quality One Care Home Health, Inc.
9221 Coleville Rd.
Silver Spring, MD 20910**

**Organization Identification Number: 519232
60-day Evidence of Standards Compliance Submitted: 8/8/2024**

**ESC Programs Reviewed
Home Care**

The Joint Commission

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The Joint Commission

Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	8/8/2024	No Requirements for Improvement	None	None

The Joint Commission Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
RC.02.01.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP & Addendum Text
RC-02.01.01	2	<p>The patient record contains information that reflects the patient's care, treatment, or services.</p>	<p>The patient record contains the following clinical information:</p> <ul style="list-style-type: none"> - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. <p>Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.</p> <p>Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care</p>

The Joint Commission

Standard	EP	Standard Text	EP & Addendum Text
			and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)



Final Accreditation Report

**Quality One Care Home Health, Inc.
9221 Codeville Rd.
Silver Spring, MD 20910**

**Organization Identification Number: 519232
60-day Evidence of Standards Compliance Submitted: 7/9/2021**

**ESC Programs Reviewed
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The Joint Commission Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	7/9/2021	No Requirements for Improvement	None	None

The Joint Commission Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
NPSG.03.06.01	Compliant
PC.02.01.03	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
NPSG.03.06.01	3	Maintain and communicate accurate patient medication information.	Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)
PC.02.01.03	1	The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.	Prior to providing care, the organization obtains or renews orders (verbal or written) from a physician or allowed practitioner in accordance with professional standards of practice and law and regulation.

Joint Commission Health Care Organization

Organization ID: 519232-Quality One Care Home Health, Inc.
9221 Codeville Rd. Silver Spring, MD 20910

Accreditation Activity- 60-day Evidence of Standards Compliance
Submission Date: 7/8/2021

Home Care Accreditation Program NPSG.03.06.01 EP 3
Likelihood: Moderate Scope: Pattern

Standard Text: Maintain and communicate accurate patient medication information.

EP Text: Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)

Finding(s): 1) Observed in Individual Tracer at Quality One Care Home Health, Inc. (9221 Codeville Rd., Silver Spring, MD) site .

In 1 of 2 home visits conducted, In 1 of 2 home visits conducted, the surveyor noted the clinician had not conducted an effective medication evaluation on a follow-up visit. For example HV#1 the patient was taken Motrin for pain and Nystatin ointment for dry skin. and these medications was not on the agency medication profile. Aquaphor was discontinued when the Nystatin started and remained on the profile. Confirmed by the LVN

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

During the inspection one of the patient's PRN medication were not listed on the MAR , this error was contributed by two main reasons:

1- Nurses did not follow agency's policy of comparing medication list on the Plan of Care and Medication Administration Record (MAR) during their shifts .

2- RN supervisor did not conduct proper medication reconciliation during their monthly supervisory visits.

Q. All corrective actions identified below must be completed prior to submission

The following measures/ systemic changes have been put in place to ensure the alleged deficient practice doesn't reoccur.

A- The Agency will re-educate all RN supervisors regarding on the proper procedure of conducting monthly nurse supervisory visits. This will include but not limited to the following procedures:

a - Developing a list of current medication

b - Developing and ensuring an updated current plan of care (Form 485) and Medication Administration Record (MAR)

c - During the supervisory visits RN supervisor will physically pull out all patient's actual medication bottles and compare it against the pharmacy label on the medication bottles, MAR, and Plan of Care, to ensure that there is no discrepancy.

B - All Nurses will be re-educated on the agency policy and procedure on reporting new, unused and discontinued medication to the agency immediately once discovered.

C - The DON/DESIGNEE will conduct monthly random audits of all active patients charts or 10% of patient's charts as census increases to ensure that proper medication reconciliation is properly done by the RN supervisors during their visits. Any negative patterns will be presented the Quality Assurance Committee for tracking and trending purposes with follow-up actions taken and implemented as need arises.

Q. All corrective actions described above were completed by

Jul 08, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The DON/DESIGNEE will conduct monthly random audits of all active patients charts or 10% of patient's charts as census increases to ensure that proper medication reconciliation is properly done by the RN supervisors during their visits. Any negative patterns will be presented the Quality Assurance Committee for tracking and trending purposes with follow-up actions taken and implemented as need arises.

Q. What is the frequency of the monitoring activities?

Monthly and quarterly.

Q. What data will be collected from these activities?

Medication error report and medication reconciliation results

Q. To who, and how often, will this data be reported?

RN supervisor will perform medication reconciliation monthly supervisory visits and report the findings each month to the DON. DON will report the data to the Quality Assurance Nurse every month.

Standard Text: The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.

EP Text: Prior to providing care, the organization obtains or renews orders (verbal or written) from a physician or allowed practitioner in accordance with professional standards of practice and law and regulation.

Finding(s): 1) Observed in Record Review at Quality One Care Home Health, Inc. (9221 Codeville Rd., Silver Spring, MD) site .

In 1 of 4 patient records reviewed, In 1 of 4 patient records reviewed, the surveyor noted the prior to providing care, the organization had not obtained orders (verbal or written) from a physician. For example HV #1 the order for perform trach care was missing how to perform the care. Flush G tube with 30 ml before feedings and 60 ml after feedings was missing what the flush was to be. Confirmed by the DON

Assigning Accountability

The Director of Nursing is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.



Final Accreditation Report

**Quality One Care Home Health, Inc.
12510 Prosperity Dr., Suite 320
Silver Spring, MD 20904**

**Organization Identification Number: 519232
60-day Evidence of Standards Compliance Submitted: 6/25/2018**

**ESC Programs Reviewed
Home Care**

The Joint Commission

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The Joint Commission Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	6/25/2018	No Requirements for Improvement	None	None

The Joint Commission Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
NPSG.15.02.01	Compliant

The Joint Commission

Appendix Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
NPSG.15.02.01	5	Identify risks associated with home oxygen therapy such as home fires.	<p>Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the licensed independent practitioner ordering the oxygen. Document the implementation of strategies to address compliance.</p> <p>Note: Other strategies to be considered include additional education, placing written reminders in specific locations, and exploring alternative living arrangements with the patient and family.</p>

Quality One Care Home Health, Inc.

Organization ID: 519232

12510 Prosperity Dr., Suite 320 Silver Spring, MD 20904

Accreditation Activity - 60-day Evidence of Standards Compliance Form

Due Date: 8/24/2018

OME Standard NPSG.15.02.01 Identify risks associated with home oxygen therapy such as home fires.

Findings: EP 5 Likelihood to Cause Harm: Moderate Scope: Limited
Observed in Individual Tracer at Quality One Care Home Health, Inc. (12510 PROSPERITY DR SUITE # 320, Silver Spring, MD) site. In 1 of 2 home visits conducted, did not implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. For example, the back up oxygen tanks were not secured in HV#1. This finding was confirmed with the Administrator.

Elements of Performance:

5. Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the licensed independent practitioner ordering the oxygen. Document the implementation of strategies to address compliance. Note: Other strategies to be considered include additional education, placing written reminders in specific locations, and exploring alternative living arrangements with the patient and family.

Assigning Accountability – Title:

Mohamed Matope RN (ADMINISTRATOR)

Corrective Actions:

DME company was notified on 6/22/18 to bring Oxygen standers to the patient's house for all oxygen cylinders. The oxygen cylinders have been placed on the standers and has been properly stored hereby ensuring safety for client and staff. Staff was in-serviced on in home safety oxygen storage and handling. RN supervisors will ensure proper oxygen cylinder storage during monthly supervisory visits.

Corrective Actions Completed Date:

6/24/2018

Sustain Compliance – Procedures:

RN supervisor will ensure proper oxygen cylinder storage during monthly supervisory visits. Oxygen storage compliance checklist has been developed by the agency for data collection and to ensure compliance by staff

Sustain Compliance – Frequency:

The oxygen storage and handling compliance will be done monthly and data from the compliance checklist will be entered and analyzed quarterly.

Sustain Compliance – Data:

Data on oxygen storage and handling will be collected from the checklist. This data will be collected and entered by the RN supervisor during the monthly supervisory visits and will include compliance on storage, handling and placement of oxygen cylinders in the stander.

Sustain Compliance – How and whom:

The oxygen storage and handling compliance data will be reported every month to the Director of Nursing and will be analyzed quarterly by Quality Assurance and Performance improvement (QAPI) team.



**HEALTHCARE PROVIDERS SERVICE
ORGANIZATION PURCHASING GROUP**
Certificate of Insurance



Print Date : 12/06/2025

PRODUCER	BRANCH	PREFIX	POLICY NUMBER	POLICY PERIOD
018098	970	HPG	0615736333	From: 12/06/25 to 12/06/26 at 12:01 AM Standard Time
Named Insured and Address:			Program Administered by:	Insurance Provided by:
Quality One Care Home Health Inc. 9221 Colesville Rd Silver Spring, MD 20910			Nurses Service Organization 1100 Virginia Drive, Suite 250 Fort Washington, PA 19034-3278 1-888-288-3534 www.nso.com	American Casualty Company of Reading, Pennsylvania 151 N. Franklin Street Chicago, IL 60606
Medical Specialty:				Code:
Nursing Firm				80963

Excludes Cosmetic Procedures

Professional Liability ("PL"): Occurrence Claims Made and Reported

Limits of Liability

\$1,000,000 each claim / \$6,000,000 aggregate

PL Limits of Liability above include the following:

*Healthcare Providers Services Liability *Placement Services Liability *Formal Review Board Activities Liability *Good Samaritan Services Liability

Abuse and Molestation Sublimits of Liability:

Damages (included within PL Limits of Liability shown above) \$25,000 aggregate
 Defense Costs (included within PL Limits of Liability shown above) \$100,000 aggregate

PL Supplementary Benefits

Licensure Defense Expenses Up to \$200 per hour / \$25,000 aggregate
 Licensure Proceeding Supplemental Costs \$500 each insured / \$500 aggregate
 Subpoena Assistance Costs \$10,000 each subpoena / \$10,000 aggregate
 Assault (includes workplace violence counseling) \$25,000 each assault incident / \$25,000 aggregate
 Patient First Aid Medical Expenses \$10,000 aggregate
 Services to Animals Property Damage \$10,000 aggregate
 Media Expense \$25,000 aggregate
 Cyber Liability and First Party Loss (Including Privacy) – Claims Made and Reported \$25,000 aggregate
 Defense Costs within limits
 Retroactive Date: 12/06/2015

General Liability ("GL"): Occurrence

GL Aggregate Limit of Liability \$6,000,000 aggregate
 Bodily Injury and Property Damage \$1,000,000 each occurrence
 (included within GL Aggregate, above)
 Personal and Advertising Injury \$1,000,000 any one person or entity
 (included within GL Aggregate, above)
 Non-Patient Medical Expenses \$25,000 any one person
 (included within GL Aggregate, above)
 Damage to Rented Property Each Premises Limit \$100,000 any one premises
 (included within Bodily Injury and Property Damage each occurrence Limit, above)
 Products-Completed Operations Aggregate Limit \$1,000,000 aggregate
 (included within GL Aggregate, above)

PL and GL/WPL (as applicable) Supplementary Benefit:

Proceeding Expense Reimbursement \$1,000 each insured per day / \$25,000 each insured per proceeding

Employment Practices Liability ("EPL"): Claims Made and Reported

\$25,000 each claim / \$25,000 aggregate

Defense only
 Retroactive Date: 12/06/2019

Total \$4,824.00

Base Premium \$4,824.00

Policy Forms and Endorsements (Please see attached list)

Doug Worman, Chief Executive Officer

Stathy Darcy, Secretary

Keep this Certificate of Insurance in a safe place. It and proof of payment are your proof of coverage. There is no coverage in force unless the premium is paid in full. To activate your coverage, please remit premium in full by the effective date of this Certificate of Insurance.

Coverage Change Date:

Endorsement Date:

Master Policy: 188711433

CNA101440 (07-23)

Page 1



Your professional liability insurance contains insuring agreements that may be written on an occurrence or a claims made and reported basis. With respect to any claims made and reported coverage such coverage applies only to claims first made against the insureds and reported to the Insurer during the policy period or any applicable extended reporting period in accordance with the provisions of this policy. Please discuss with your Program Administrator.

DEFENSE WITHIN LIMITS: WHERE DEFENSE WITHIN LIMITS IS INDICATED BELOW OR BY ENDORSEMENT, THE AMOUNT OF MONEY AVAILABLE TO PAY SETTLEMENTS OR JUDGMENTS AGAINST YOU UNDER SUCH SPECIFIED COVERAGE PART WILL BE REDUCED AND MAY BE EXHAUSTED BY DEFENSE EXPENSES, INCLUDING BUT NOT LIMITED TO FEES PAID TO ATTORNEYS TO DEFEND YOU.

The application for the policy and any and all supplementary information, materials, and statements submitted therewith shall be maintained on file by us or our Program Administrator and will be deemed attached to and incorporated into the policy as if physically attached.

POLICY FORMS & ENDORSEMENTS

The following are the policy forms and endorsements that apply to your current professional liability policy.

FORM #	FORM DESCRIPTION
CNA101429 (07-23)	General Terms and Conditions
CNA101432 (07-23)	Healthcare Providers Professional Liability Coverage Part (Occurrence)
CNA81753 (03-15)	Coverage & Cap on Losses from Certified Acts Terrorism
CNA81758MD (01-21)	Notice - Offer of Terrorism Coverage & Disclosure of Premium
CNA101455 (07-23)	Business Owner Coverage Extension Endorsement
CNA101519 (07-23)	Entity Endorsement (Including Specified Procedures and Services and Office Sharing Exclusions)
CNA101553 (07-23)	Table of Contents - General Terms and Conditions
CNA101557 (07-23)	Table of Contents- Coverage Part Occurrence Form
CNA101559 (07-23)	Table of Contents - Employment Practices Liability Defense Only
CNA101562 (07-23)	Table of Contents - General Liability
CNA101577 (07-23)	Biometric Privacy Exclusion Endorsement
CNA101512MD (07-23)	Cancellation & Nonrenewal Amendatory Endorsement
CNA101581 (07-23)	Additional Insured Endorsement (General Liability)
CNA62842MD (09-12)	Policyholder Notice - claims history
CNA79802MD (08-14)	Maryland Policyholder Notice
CNA101435 (07-23)	General Liability Coverage Part
CNA101441 (07-23)	Cosmetic Procedures Exclusion Endorsement
CNA101443 (07-23)	Media Event Expenses Supplementary Benefits Endorsement
CNA101444 (07-23)	Employment Practices Liability Coverage Part (Defense Costs only)
CNA101478 (07-23)	Named Insured "D/B/A" (Doing Business As) Endorsement
CNA101479 (07-23)	Cyber Liability and First Party Loss (Including Privacy) Endorsement
CNA101501 (07-23)(04)	Agreement to Provide Notice of Cancellation

EXHIBIT 15

Utilization Tables

Quality One Care Home Health, Inc.

HHA PROJECT

Anne Arundel County, Montgomery County, Prince George's County,
Calvert County, Charles County & St. Mary's County

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MHCC Survey & Utilization Tables FY 2023 (Excel Attachments)