Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	747984	03/19/2026
Name of Provider or Supplier	**Street Address, City, State**	
Jubilee Care @ Home Health Care Services Llc	300 Jackson Street, Richmond, TX	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
G0606	Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure coordination of care /services with other providers involved in the care of the patients for 2 of 5 patients (Patient #4 and #5), whose records were reviewed in that: The agency failed to coordinate the schedule of visits with the Physical Therapist and Occupational Therapist to optimize client care in 2 of 5 (Patient #4 and #5) records reviewed. Failure of the agency to not coordinate care with other services could place the patients at risk of further decline in the patients mobility, health, and possible hospitalization when care was not provided as ordered. Findings Include: Review of the agency's policy titled "Monitoring Patient/Client Care/ Coordination of Care/Services" last reviewed date 01/01/26 revealed in part... " Policy: II. The agency will collaborate with other organizations providing services (i.e, medical equipment, other home health agencies, outpatient clinics, etc.), the patient/client, and their

representative (if applicable) to ensure appropriate coordination of care/services. Procedure: I. The agency will: C. Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient/client needs and factors that could affect patient/client safety and treatment and the coordination of care /services provided by all disciplines.

Patient #4

Record review of Patient #4's ECR revealed a POC with a SOC date of 09/12/25 for a certification period from 01/24/2026 to 03/24/2026 diagnosis included: after care following joint replacement (removes and replaces damaged or arthritic joint parts with artificial prostheses to relieve pain and restore mobility, commonly for knees, hips, and shoulders). Risk Profile: Patient #4 had multiple risk factors, including history of two or more falls leading to hip replacement, and recent multiple hospitalizations. Orders and Treatments: SN 1w10 (1 time a week for 10 weeks), PT 1w1(1 time a week for 1 week) to evaluate & treat week of 1/25/26, OT 1w1(1 time a week for 1 week) to eval & treat week of 1/25/26.

Record review of ECR document for Patient # 4, titled OASIS-E1 Start of Care revealed in part Patient Care Preferences: Patient # 4 and FM expressed willingness to participate in recommended home health services, including skilled nursing visits and physical therapy. Patient # 4 is motivated for recovery and rehabilitation following hip replacement surgery. Signed by RN A and dated 01/24/26.

Record review of documentation titled RN-Skilled Nursing Visit revealed in part Coordination Plan: Missing PT/OT evaluations and coordination of therapy services for Patient # 4. The document was signed by RN B and dated 01/29/24.

Record review did not reveal that the agency provided Patient # 4 with PT evaluation and OT evaluation during certification period of 01/24/2026 - 03/24/2026.

Patient # 5

Record review of Patient #5's ECR revealed a POC with a SOC date of 08/01/2025 for a certification period from 08/01/2025 -09/29/2025 diagnosis included: chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs) and history of falling. Orders and Treatments: SN: 1W9 (1 time a week for 9 weeks), PT: Eval and treat, OT:1w1(1 time a week 1 week) effective week of 8/3/25.

Further record review of a document titled, 'Referral revealed in partOT to eval and treat. The document was signed by Staff I and dated 08/04/25.

Record review of a document titled, 'Communication Note' revealed in part, " COTA-'Communication Note for Patient #5-Therapist unable to see Patient #5 due to being sick (food poisoning) SSS/pts notified and dated 08/15/25. COTA-Therapist unable to see Patient #5 due to being sick (food poisoning) SSS/pts notified and dated 08/16/25. COTA-Schedule conflict dated 09/05/25, and 09/11/25.

Record review of a document titled, 'Communication Note' revealed in part, " Patient #5s FM called and was requesting for a new OT that she has requested for, CM explained to Patient #5s FM that we (the agency) are yet to find someone else that will provide the care for Patient #5 and we have informed the MD for transfer to another agency. The document was signed by RN H and dated 09/25/25.

Record review of Patient #5's ECR revealed a POC with a SOC date of 08/01/2025 for a certification period from 01/28/2026 - 03/28/2026 diagnosis included: chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs) and history of falling. Orders and Treatments: SN: effective 02/01/26 2m2 (2 times a month for 2 months), PT: 2w3 (2 times a week for 3 weeks), 1w6 (1 time a week for 6 weeks).

Record review of a document titled, 'Complaint Received' revealed in part, " Patient #5s FM contacted the agency regarding concerns about therapy services. FM reported that Patient #5s therapy had been delayed despite visits approved by insurance. The document was signed by the Adm/DON and dated 01/27/26.

Record review of a document titled, 'Communication Note' revealed in part, "Spoke with Patient #5s FM regarding PT Re-Evaluation. Patient #5s FM voiced frustration with this process as Patient #5 has not had previous re-evaluations. FM reported previous PT was not seeing Patient #5 every 30 days. Discussed re-evaluation were required to re-evaluation every 30 days to complete supervisory visit and Patient #5s progress per therapy practice acts. The document was signed by the Adm/DON and dated 02/12/26.

Attempts made on 03/19/26 to interview the following staff members: PT, PTA, COTA C, RN A and RN B, no return calls received before exit.

During an interview on 03/19/26 at 2:03 p.m. with the Adm/DON the surveyor presented the above findings. The Adm/DON stated, "that scheduling patient visits are overseen by the CM and DON but there had been some oversight issues with scheduling because the agency was still looking to hire a new schedular for patient care visits. The Adm/DON stated the agency had identified issues with Agency G due to staff not making scheduled visits and that the agency had also found failures with Agency G evaluations not being completed, patient service failures and problems with communications from Agency G staff for not calling patients to arrange visits. The Adm/DON stated the risk of staff not coordinating physician ordered plans of care and services was a decline in patient health and the potential for being hospitalized.