| **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**<br>(Each deficiency should be preceded by full regulatory or LSC identifying information) |
|---|---|
| **G0710** | Provide services in the plan of care<br>CFR(s): 484.75(b)(3)<br><br>Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care;<br><br>This ELEMENT is not met as evidenced by:<br>Based on record review and interview, the agency failed to provide services as ordered by the physician or allowed practitioner as indicated in the plan of care for 2 of 5 patients (Patient #4 and #5), whose records were reviewed in that:<br><br>Physical Therapy (PT) services were not provided to Patients #4 and #5 as ordered by the physician in the written plan of care.<br><br>Occupational Therapy (OT) services were not provided to Patients #4 and #5 as ordered by the physician in the written plan of care.<br><br>Failure of the agency to conform with physician orders could place the patients at risk of harm due to not receiving care as ordered.<br><br>Findings Include:<br><br>Review of the agency's policy titled "Plan of Care" last reviewed date 01/01/26 revealed in part... " Policy: I. The agency will use data/information gathered during patient/client assessments in the care planning process which involves the identification of patient/client goals, actions or interventions that will resolve or alleviate the patients/clients problems and or needs. Procedure: I. The appropriate licensed professional staff member, with physician or allowed practitioner |

participation, is responsible for developing the Plan of Care within three to five days of the initial assessment. B. A registered physical therapist initiates the Plan of Care for PT care and for physical therapy assistant care provided as an extension of PT services. C. A registered occupational therapist initiates the plan of Care for OT care and for OTA care provided as an extension of OT services.

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.