STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105613	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak Healthcare and Rehabilitation Center	1620 Helvenston St SE Live Oak, FL 32064

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure food items were stored in a safe and sanitary manner. Findings include:During an observation on 6/22/2026 at 9:30 AM, water was pouring from the dishwasher in the main kitchen onto the floor resulting in pooled water on the kitchen floor. During interview on 6/22/2026 beginning at 9:30 AM, the Certified Dietary Manager stated water had routinely poured from the dishwasher onto the kitchen floor during her employment. During interview on 6/22/2026 beginning at 9:30 AM, Staff A, Dietary Aide, stated, It's been like that for a while [water pouring from the dishwasher]. I think a part may be broken.During an observation on 6/22/2026 at 9:38 AM, there were two (2) thawed 4 ounce containers of a nutritional supplement stored in the refrigerator of the East Hall nourishment room. There were instructions written on the supplement carton that directed the thawed substance be used within 14 days of thawing. There was no thawed-on date inscribed on the supplement cartons.During interview on 6/22/2026 beginning at 9:38 AM, the Certified Dietary Manager stated the cartons of thawed supplement should have a date inscribed on them noting the date the supplements were thawed.During an observation on 6/22/2026 at 9:48 AM, there was no working thermometer in the South Hall nourishment room freezer, and there was one (1) carton of thawed supplement. There were instructions written on the supplement carton that directed the thawed substance be used within 14 days of thawing. There was no thawed-on date inscribed on the supplement carton. There was a speckled black and brown substances on the interior top, right, and left sides and lower metal guards of the ice machine. The flooring on the left side of the ice machine was discolored with a dark brown substance, and water was pooled at the door of the nourishment room. During an interview on 6/22/2026 beginning at 9:48 AM, the Certified Dietary Manager stated the nutritional supplements should have been given to residents last night before the observation. There is no working thermometer in the South Hall nourishment room freezer, there is speckled black and brown substances on the interior top, right, and left sides and lower metal guards of the ice machine and the ice machine needs cleaning. The flooring on the left side of the ice machine is discolored with a dark brown substance and water is pooled at the door of the nourishment room. Review of the policy and procedure titled, Cold Foods last reviewed 1/28/2026, read, 2. All perishable foods will be maintained at a temperature of 41 F [Fahrenheit] or below, except during necessary periods of preparation and service. 3. Freezer temperatures will be maintained at a temperature of 0 F [Fahrenheit] or below. 4. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded.Review of the policy and procedure titled, Ice last reviewed 1/28/2026, read Ice will be prepared and distributed in a safe and sanitary manner. 2. The Dining Services Director will coordinate with the Maintenance Director to ensure that the ice machine will be disconnected, cleaned and sanitized quarterly and as needed, or according to manufacturer guidelines. 4. Ice bins will be cleaned monthly and as needed.Review of the policy and procedure titled, Equipment last reviewed 1/28/2026, read All foodservice equipment will be clean, sanitary, and in proper working order. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. 2. All staff members will be properly trained in (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaning and maintenance of all equipment. 5. The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed. 6. The Dining Services Director will notify the Administrator when repairs are completed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to ensure an updated Preadmission Screening and Resident Review (PASRR) was completed for a resident diagnosed with a serious mental disorder for 1 of 4 residents, Resident #7, reviewed for PASRR. Findings include: Review of Resident #7's Face Sheet documented a diagnosis of, Psychosis not due to a substance or known physiological condition Onset Date 3/19/2025. Review of Resident #7's PASRR dated 06/14/2024 did not document the resident had a diagnosis of psychosis not due to a substance or known physiological condition. Review of Resident #7's Psychological progress note dated 5/18/2026 documented psychosis as a diagnosis. During an interview on 6/24/2026 at 11:40 AM, the Assistant Director of Nursing confirmed a Level I PASRR had not been updated for Resident #7 to include the mental health diagnosis of psychosis. During an interview on 6/24/2026 at 9:10 AM, the Social Services Director stated, The IDT [Interdisciplinary] Team is responsible for PASRR'S. Review of the policy and procedure titled, Administration PASSR Significant Change read, Significant Change: is a major decline or improvement in a resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions; the decline is not considered self-limiting (NOTE: Self-limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical interventions to resolve the condition. Requires interdisciplinary review and/or revision of the care plan. This does not change the facility's requirement to immediately consult with a resident's physician of changes.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate Preadmission Screening and Resident Review (PASRR) was completed for residents with a serious mental disorder diagnosis at the time of admission for 2 of 6 residents, Residents #15 and #176, reviewed for PASRR.Findings include:1) During an interview on 06/22/2026 at 9:40 AM Resident #15 stated he was tired and he did not want to talk.Review of Resident #15's medical record documented the resident was admitted on [DATE], with a readmission on [DATE] and diagnoses to include major depressive disorder, recurrent, unspecified; restlessness and agitation.Review of Resident #15's PASRR dated 5/08/2026 revealed there were no mental illnesses or suspected mental illnesses documented. Review of Resident #15's Psychiatric admission Note dated 5/15/2026 read, Patient seen today for an initial psych evaluation to rule out symptoms of depression and anxiety given current physical functioning and reduced mobility. Patient currently receives psychotropic medication management. PMH [Primary Medical History]/Problem List: Patient has an active mental health diagnosis. F33.9: major depressive disorder, recurrent, unspecified Status: Resolved Onset Date: 05/10/2026; F33.0: Major depressive disorder, recurrent, mild Status: Active Onset Date: 05/17/2026; R45.1: restlessness and agitation Status: Active Onset Date: 05/10/2026. Review of Systems: Depression, Depressed mood, Insomnia, Loss of energy, Markedly diminished interest; Anxiety, Being easily fatigued. Assessment/Plan: F33.0 - Major depressive disorder, recurrent, mild. Staff to monitor, document, and report worsening symptoms of depressive symptoms: feelings of sadness/depressed mood hopelessness poor concentration loss of interest/lack of pleasure sleep disturbances tiredness and decreased energy change in weight and appetite feelings of worthlessness/guilt suicidal ideations, suicidal intent, suicidal plan. Continue Escitalopram 5 mg [milligrams] daily.Review of Resident #15's Care Plan read, Focus - [Resident #15's name] has a psychosocial well-being problem r/t [related to] lack of motivation and little to no interest in doing things he enjoys, DX [diagnosis] depression. Date Initiated: 05/11/2026. Focus - The resident uses antidepressant medication r/t depression/insomnia. Date Initiated: 05/21/2026. Focus - [Resident #15's name] has DX: depression and agitation. Resident currently expressed feeling down and depressed, trouble sleeping. Date Initiated: 05/11/2026. Review of Resident #15's physician orders dated 5/08/2026 read, Quetiapine Fumarate Oral Tablet 25 MG [milligrams] (Quetiapine Fumarate): Give 25 mg by mouth one time a day for agitation.Review of Resident #15's physician orders dated 5/09/2026 read, Escitalopram Oxalate Tablet: Give 1 tablet by mouth one time a day for depression.2) Review of Resident #176's medical record documented the resident was admitted on [DATE] with medical diagnoses to include dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.Review of Resident #176's PASRR dated 6/17/2026 documented the resident had no mental illness or suspected mental illness.Review of Resident #176's Acute Care Progress Note dated 6/19/2026 read, The patient is a [AGE] year-old female skilled nursing facility resident with a medically complex history significant for encephalopathy, acute kidney failure, dementia, hyperlipidemia, essential hypertension, end stage renal disease, and dependence on renal dialysis who was evaluated today as a new admission while receiving on site hemodialysis. At the time of examination, the patient appeared comfortable and in no acute distress. She was alert and oriented, although speech was limited and communication consisted primarily of brief verbal responses and nonverbal gestures including head nodding and head shaking. Due to underlying cognitive impairment and communication limitations, the patient was unable to clearly express her anticipated length of stay or discharge plans. Given her history of end stage renal disease requiring chronic dialysis in conjunction with dementia and prior encephalopathy, the patient remains medically fragile and at increased risk for metabolic derangements and clinical decompensation. A comprehensive review of her chronic conditions and current treatment needs was performed as part (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the admission evaluation. Problem List: N18.6 - End stage renal disease F03.90 - Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Plan: Continue scheduled hemodialysis treatments on Monday, Wednesday and Friday and coordinate care with nephrology and dialysis staff regarding treatment tolerance and volume status: Maintenance dialysis is essential for management of end stage renal disease and prevention of life threatening metabolic and fluid abnormalities.During an interview on 6/24/2026 at 9:45 AM the Regional Nurse Consultant stated that the Social Services Assistant was responsible for reviewing PASRRs when residents were first admitted . The IDT [Interdisciplinary Team] team met the day after the resident was admitted making sure the pieces were all in place. During an interview on 6/24/2026 at 10:35 AM the Social Services Assistant stated she reviews the screening PASRRs when residents are first admitted and they are reviewed the next day by the IDT team in the Clinical Meeting. They review the PASRRs to see if the resident may need special services, require a level II PASRR, to identify any mental illness that would require special services or possibly other review or other [clinical/residential] setting. They would go through the diagnoses to identify any that would trigger [the need for special services, additional review, or another setting]. If a diagnosis was not checked [on the screening PASRR] they would go digging to see if there was a history of the condition, if it was an active diagnosis, or if the resident was being treated. If there were clinical questions or concerns, they would refer it to the ADON (Assistant Director of Nursing).During an interview on 6/24/2026 at 10:42 AM the ADON stated that if a resident was admitted with a diagnosis of a mental illness and it wasn't on the PASRR then the PASRR should have been updated.Review of the policy and procedure titled, Administration - PASRR, with a last review date of 1/28/2026 read, Purpose: To ensure compliance with regulations for Preadmission Screening Resident Reviews. Policy: The facility will ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and individuals identified with MD or ID are evaluated to receive care and services in the most integrated setting appropriate to their needs by coordinating with the appropriate, State-designated authority. The facility will ensure that individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need and the most appropriate setting, when a significant change in their status occurs. Preadmission Screening and Resident Review (PASRR): is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/ or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); 3) and receive the services they need in those settings. Procedure - Preadmission Screening: 1. The External Liaison or Internal admission Staff/Designee will obtain a completed pre-admission screen (PASRR Level I) on individuals being admitted to the SNF prior to admission.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received needed care and services for the application of topical medication for 1 of 3 residents, Resident #24, reviewed for skin conditions.Findings include:During an observation on 6/22/2026 at 9:35 AM Resident #24's left elbow was red and swollen.During an interview on 6/22/2026 at 9:35 AM Resident #24 stated the facility did an x-ray on his left elbow that didn't show anything. He was not receiving any treatment. Review of Resident #24's medical record documented the resident was admitted on [DATE] with medical diagnoses to include cellulitis of left lower limb; type 2 diabetes mellitus without complications; acute kidney failure, unspecified; unspecified atrial fibrillation (an irregular and often rapid heart rate); peripheral vascular disease, unspecified; personal history of transient ischemic attack (a temporary blockage of blood flow to the brain, often called a mini-stroke), and cerebral infarction without residual deficits (occurs when brain tissue dies due to a lack of blood flow).Review of Resident #24's physician orders dated 6/04/2026 read, Diclofenac Sodium External Gel 3% (Diclofenac Sodium (Actinic Keratoses)): Apply to left elbow topically every 8 hours for inflammation for 5 days. There was no amount or dose documented in the order.Review of Resident #24's physician orders dated 6/14/2026 read, Diclona External Gel 1-4.5% (Diclofenac Sodium-Lidocaine HCl (Topical)): Apply to Low back, shoulder, elbow topically four times a day for pain for 10 days. There was no amount or dose documented in the order.Review of Resident #24's MAR/TAR (Medication Administration Record/Treatment Administration Record) for the period of 6/01/2026 through 6/23/2026 documented Diclofenac Sodium External Gel 3% (Diclofenac Sodium (Actinic Keratoses)): Apply to left elbow topically every 8 hours for inflammation for 5 days -Start Date 06/04/2026 2200 (10:00 PM). The MAR documented the medication was administered as ordered by the physician three times daily from 6/04/2026 through 6/09/2026 by the initialing of the licensed nurse.Review of Resident #24's MAR/TAR for the period of 6/01/2026 through 6/23/2026 documented Diclona External Gel 1-4.5% (Diclofenac Sodium-Lidocaine HCl (Topical)): Apply to Low back, shoulder, elbow topically four times a day for pain for 10 days -Start Date 06/14/2026 1500 [3:00 PM]. There was documentation of the application of the physician ordered medication for two to four times daily from 6/14/2026 through 6/23 2026. The MAR documented the medication was not administered per the physician's order. Dated 06/17/2026 the medication was initialed as administered twice and dated 6/21-22/2026 the medication was initialed as administered three times.During an interview on 6/23/2026 at 12:20 PM Resident #24 stated the nurses are supposed to be putting something on his elbow four times a day, but they hadn't been putting it on.During an interview on 6/23/2026 at 1:32 PM Staff C, LPN (Licensed Practical Nurse) stated she had applied Resident #24's Voltaren (Diclofenac Sodium) to his shoulder and back, but she was not aware that it was also supposed to be applied to his elbow. She used a medicine cup when dosing the gel, but she did not fill it completely. The order was usually dosed in grams, but she would have to check with the physician about how much she was supposed to apply. Review of Resident #24's most recent MDS (Minimum Data Set) Assessment, a Medicare 5-day assessment dated [DATE] documented his BIMS Score as 14 out of 15 which indicated he was cognitively intact.Review of Resident #24's Care Plan read, Focus - The resident is AT RISK FOR or has POTENTIAL FOR pain r/t [related to] history of surgery, other disease/disorder causing pain, left elbow. Date Initiated: 03/25/2026. Interventions included - Administer and monitor for effectiveness and for possible side effects from routine and/or PRN [as needed] pain medications (see MAR/physician orders.) Date Initiated: 03/25/2026.Review of the mayoclinic.org/drugs-supplements/diclofenac-topical-application-route/description/drg-20063434 read, Dosing: The dose of this medication will be different for different patients. Follow your doctor's orders or the directions on the label. The amount of medication you take depends on the strength of the medicine. Also, the number of doses you take each day, the time allowed between doses, and the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	length of time you take the medicine depend on the medical problem for which you are using the medicine. Precautions: It is very important that your doctor check your progress at regular visits. This will allow your doctor to make sure this medicine is working properly and to decide if you should continue to use it. Blood and urine tests may be needed to check for unwanted effects. This medicine may increase your risk of having a heart attack or stroke. This is more likely in people who already have heart disease or in people who use this medicine for a long time. This medicine may cause bleeding in your stomach or bowels. These problems can happen without warning signs. This is more likely if you have had a stomach ulcer in the past, if you smoke or drink alcohol regularly, are over [AGE] years of age, are in poor health, or are using certain other medicines (eg [for example], other NSAIDs [non-steroidal anti-inflammatory drug], steroid medicine, blood thinners).Review of the policy and procedure titled Clinical-Medication Administration, with a last review date of 1/28/2026, read, Purpose: to administer medications as per providers orders and in accordance with regulatory guidelines and practice standards. Guidelines for medication administration: read orders to ensure the information is clear and accurate. Clarify questions with the charge nurse or the provider as needed. Observe the rights of medication administration right dose.Review of the policy and procedure titled Clinical - Physician Orders, with the last review date of 1/28/2026 read, Purpose: Physician/physician extender's orders are administered upon the clear complete order of an individual lawfully authorized to prescribe. Procedure: B.) Order Clarification Requests: 2. When an order is received, if there is any question regarding the Rights of Medication Administration (i.e., right resident, right medication, right dose, right route, right frequency), the licensed nurse will attempt to contact the prescribing physician to obtain clarification. Communication/communication attempt should be documented in the clinical record.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review, the facility failed to ensure an assistive optical device was provided for 1 of 3 residents, Resident #57, reviewed for assistive devices. Findings include:During an observation on 06/22/2026 at 10:00 AM, Resident #57 was observed watching television, the resident was not wearing eyeglasses.During an interview on 06/22/2026 at 10:00 AM, Resident #57 stated she had an eye appointment in January but had not received the glasses she was told would be coming for her.Review of Resident #57's electronic medical record listed a diagnosis of hypertensive retinopathy.Review of the optometry consultation dated 01/21/2026 completed by (name of the optometry provider) read under the section titled Fitting/Adjusting Specs/Ordering bifocal eyeglasses were ordered for Resident #57.During an interview on 06/24/2026 at 1:50 PM, Staff H, Social Services stated an optometrist visits the facility monthly. Eyeglasses are typically delivered to the facility monthly; however, no eyeglasses for Resident #57 were included in the last shipment. The facility has experienced issues with the optometry provider changing physicians. Resident #57 was seen by optometry on 01/21/2026 and the last optometry service provided at the facility was on 03/23/2026. Staff H stated she had not contacted the optometry provider to determine the status of Resident #57's eyeglasses.Review of the electronic medical record revealed no documentation the ordered eyeglasses had been received by the facility or provided to Resident #57. There was no documentation in the record the facility staff had followed up with the optometry provider regarding the delayed delivery of the eyeglasses.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the facility was free of accident hazards when not securing oxygen tanks/cylinders in 1 of 3 resident's rooms, Resident #176, reviewed for respiratory care.Findings include: During an observation on 6/22/2026 at 9:40 AM Resident #176 was sitting in her wheelchair beside her bed. There was an oxygen cylinder/tank standing unsecured on the floor between the Resident's bed and the bathroom (Photographic evidence obtained). During an observation on 6/22/2026 at 11:30 AM Resident #176 was out of her room. There was an oxygen tank containing over 1000 PSI (pounds per square inch) of oxygen standing unsecured on the floor between the Resident's bed and the bathroom. (Photographic evidence obtained). During an interview on 6/22/2026 at 11:35 AM Staff E, CNA (Certified Nursing Assistant) stated Resident #176's oxygen tank should not be sitting on the floor; it should be in a rolling cart or on her wheelchair. The oxygen tank sitting on the floor is not clean and is not safe. During an interview on 6/22/2026 at 11:37 AM Staff C, LPN (Licensed Practical Nurse) stated Resident #176's oxygen tank had to be in a holder for safety reasons. During an interview on 6/22/2026 at approximately 1:00 PM the ADON (Assistant Director of Nursing) stated portable oxygen tanks needed to be kept in either rolling carts or strapped on the resident's wheelchair. Review of the policy and procedure titled Nursing - Oxygen Administration with the last review date of 1/28/2026, read, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 3. Assemble the equipment and supplies as needed. Equipment and Supplies: The following equipment and supplies will be necessary when performing the procedure: 3. Portable oxygen cylinder (secured to O2 [oxygen] cart or wheelchair). Safety Considerations: 4. E-tanks have a high amount of pressure and can be dangerous if not properly secured.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for 1 of 3 residents, Resident #176, reviewed for respiratory care.Findings include: During an observation on 6/22/2026 at 9:40 AM Resident #176 was sitting in her wheelchair beside her bed. The resident was being administered oxygen at 2 liters per minute (2L/min) via nasal canula attached to an oxygen concentrator. Review of Resident #176's medical record documented the resident was admitted on [DATE] with medical diagnoses to include encephalopathy, unspecified; dependence on renal dialysis; end stage renal disease; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #176's physician orders for the period of 6/18/2026 through 6/23/2026 revealed there was no physician order for the administration of oxygen. During an observation on 6/24/2026 at approximately 10:00 AM Resident #176 was lying in bed. The resident was being administered oxygen at 2L/min via nasal canula attached to an oxygen concentrator. During an interview on 6/24/2026 at 10:48 AM Staff D, LPN (Licensed Practical Nurse) stated Resident #176 was on oxygen; she had taken her vital signs earlier that morning and she (Resident #176) was being administered oxygen. They did vitals every shift. If the resident was on oxygen there should be an order and the nurses would document on the MAR (Medication Administration Record, the administration of oxygen. The admission Nurse would start a new resident on oxygen based on the hospital paperwork. If the resident came on oxygen and there wasn't an order, the admission Nurse should contact the MD (Medical Doctor) for an order and clarification of the rate. Staff D, LPN confirmed there was no physician order in the medical record for the administration of oxygen for Resident #176. During an interview on 6/24/2026 at 4:14 PM the DON (Director of Nursing) stated the expectation is for a resident being administered oxygen there is to be a physician's order for the oxygen that included the rate, the delivery method, and the duration. Nurses are expected to assess the resident and document their findings. The DON confirmed there was no physician order in the medical record for the administration of oxygen for Resident #176. Review of the policy and procedure titled Nursing - Oxygen Administration, with the last review date of 1/28/2026, read, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Oxygen is used to treat known or suspected hypoxia or hypoxemia. Oxygen is also used to treat increased work-of-breathing. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Process: 1. Verify Physicians orders. Review of the policy and procedure titled Clinical - Physician Orders, with the last review date of 1/28/2026 read, Purpose: Physician/physician extender's orders are administered upon the clear complete order of an individual lawfully authorized to prescribe. Procedure: B.) Order Clarification Requests: 2. When an order is received, if there is any question regarding the Rights of Medication Administration (i.e., right resident, right medication, right dose, right route, right frequency), the licensed nurse will attempt to contact the prescribing physician to obtain clarification. Communication/communication attempt should be documented in the clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105613	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak Healthcare and Rehabilitation Center	1620 Helvenston St SE Live Oak, FL 32064

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent the possible spread of infection when staff failed to use appropriate Personal Protective Equipment (PPE) when entering contact precautions rooms for 2 of 3 residents, Residents #38 and #89, reviewed for transmission-based precautions.Findings include:During an observation on 6/22/2026 at 11:08 AM Resident #38's door had a sign displayed documenting Contact Isolation Precautions and there was a Personal Protective Equipment (PPE) holder containing gowns, gloves, and disposable equipment. A Housekeeper was observed entering the room with a spray bottle and a cloth. The Housekeeper donned a pair of gloves before entering the room, and remained in the room for approximately five (5) minutes. She could be overheard conversing in Spanish with Resident #38.During an interview on 6/22/2026 at 11:12 AM Staff E, Housekeeper indicated she did not speak English. She shook her head yes to indicate that she had seen the isolation sign hanging on Resident #38's door and the PPE.Review of Resident #38's physician orders dated 6/16/2026 read, Isolation type: Contact - Diagnosis: ESBL: urine every shift for 7 Days.2) During an observation on 6/22/2026 at 11:18 AM there was a sign posted on Resident #89's door documenting the resident was on Contact Isolation precautions. There was a PPE holder on the door that contained isolation gowns, gloves, and disposable equipment. Staff F, CNA (Certified Nursing Assistant) walked in the room passing Resident #89 sitting in a wheelchair. Staff F, CNA picked up an item and spoke with the resident. She did not don gloves or a gown before entering the room. During an interview on 6/26/2026 at 11:00 AM Staff F, CNA stated for Contact precautions she knew that she needed to put everything on (PPE) and watch what she touched when she was in the resident's room (Resident #89). She had entered Resident #89's room on Monday (06/22/2026) without putting on gloves or a gown because she didn't think he was in the room. She knew she should put on a gown and gloves to go into a room with Contact precautions.During an interview on 6/24/2026 at 1:30 PM the Infection Preventionist stated for residents on Contact Isolation precautions, the staff would, [NAME] your gown and gloves, that's all you need for contact. Put it [PPE/gown and gloves] on before you enter the room and take it off before they leave the room. Between me and [name of the Assistant Director of Nursing] we do education for everyone. Review of Resident #89's physician orders dated 6/18/2026 read, Isolation type: (specify - Contact) Diagnosis: (MRSA [Methicillin Resistant Staphylococcus Aureus] /Enterococcus Faecalis in wound) every shift for 10 DaysReview of Resident #89's medical record documented the resident was admitted on [DATE] with medical diagnoses to include local infection of the skin and subcutaneous tissue, unspecified; polyneuropathy, unspecified (primary).Review of the policy and procedure titled, Infection Prevention and Control Program Overview with the last review date of 1/28/2026 read, Policy: The primary mission is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Elements of the Program include: Standards, guidelines, and practices which promote consistent adherence to evidence-based infection control practices. Definitions: Transmission-based precautions (a.k.a. [also known as] Isolation Precautions): actions (precautions) implemented, in addition to standard precautions, that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections. Note: Although the regulatory language refers to isolation, the nomenclature widely accepted and used in this guidance will refer to transmission-based precautions instead of isolation.Review of the policy and procedure titled, Infection Control-Transmission Based Precautions with the last review date of 1/28/2026 read, Purpose: To identify the need for transmission-based precautions and implementation of infection control practices necessary to prevent the spread of pathogens. Procedure: 2. Contact Precautions: c. Health care personnel caring for residents on contact precautions wear a gown and gloves for interactions that may involve (continued on next page)

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	105613	A. Building B. Wing	06/25/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry is preferred prior to prolonged resident contact and doffing the PPE before exiting the room is done to contain pathogens.