

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Live Oak Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2951 Hwy 281 George West, TX 78022	
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 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, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation, and sanitation.1.The facility failed to ensure the walk-in freezer did not have ice accumulation inside of it.2.The facility failed to ensure all items in the refrigerator were labeled and dated.3.The facility failed to ensure the resident's refrigerator in the 400 hall did not have staff items in it.4.The facility failed to ensure items in the resident's refrigerator in the 400 hall were labeled and dated.5. The facility failed to ensure dented food-holding pans were removed from service. These failures could place residents who received meals and/or snacks from the kitchen or resident refrigerator at risk for food contamination and food-borne illness.Findings included:During the initial tour of the kitchen on 07/06/26, beginning at 11:20 am, 8 trays of varied beverages were revealed in covered plastic glasses that were not dated or labeled. Each tray held 8-24 glasses. The walk-in freezer door was difficult to open and close. There was approximately a half-inch layer of ice around the seal of the door and the jam. There was heavy ice build-up behind the fan/condenser along with its tubing in the walk-in freezer. There were multiple dented food-holding pans on the clean rack. The corners of 4 food holding pans had crevices from dents in the corners of the pans. Observation of the resident-designated refrigerator in the 400 hall on 07/06/26 at 12:02 pm revealed a personal bag with a container of mustard, a bottle of water, and zip-type baggies containing sandwich meat, bread, and fruit. The bag and its contents were neither labeled nor dated. There was a plastic container of fruit that appeared to be soggy. The container was not labeled or dated. There was an open 12-pack of soda with a resident's name on it next to the personal bag. Observation and revisit of the walk-in freezer on 07/08/26 at 2:00 pm revealed that the ice from the fan/condenser and its tubing had been chipped off, leaving chunks of ice on the floor and on top of boxes of product on the shelf under the fan/condenser. The pieces of ice had black objects stuck in them, similar to the insulation that was around the fan/condenser tubing. The chunks of ice on the floor were a hazard to walk on due to potential tripping and/or slipping. In an interview with the DM on 07/06/26 at 11:30 am, she said the dietary aids and/or the cook were responsible for labeling and dating everything in all refrigerators and the freezer. She said the facility used an electronic work order system and she had put in a work order about the walk-in freezer door about a month ago. She said she was unaware the dents and crevices in the food holding pans could harbor bacteria.In an interview with the [NAME] on 07/06/26 at 11:32 am, she said everyone was responsible for making sure items in the refrigerators, freezer, and storage room were labeled and dated. She said they were using the drinks today, but they should have been labeled and dated. In an interview with the charge nurse, LVN F on 07/07/26 at 12:02 pm, she said the refrigerator in the 400 hall was for residents only. She said staff had a breakroom, and there was no excuse for keeping personal items in the resident's refrigerator. She said the (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a QAPI plan that described the process for conducting quality assessment and assurance activities, including the process on how the committee would identify and correct quality deficiencies for one of one laundry rooms, five of eighteen residents (Resident #1, Resident #49, Resident #8, Resident #10, and Resident #3), and one of one kitchens. The facility failed to implement an effective QAPI program that identified, monitored, and corrected systemic quality deficiencies, including infection prevention and control. The facility failed to ensure the WCN performed hand hygiene for at least 20 seconds prior to and after performing Resident #1's wound care and performed hand hygiene after glove removal. CNA A performed hand hygiene for at least 20 seconds prior and after assisting the WCN with Resident #1's wound care. The facility failed to ensure the ES maintained the integrity of clean laundry by hanging laundered slings and heel protectors on the dirty side of the laundry area instead of the clean side. Laundry staff dried wet linen and resident clothing after washing them. The facility failed to ensure LVN B put on a gown prior to administering medication through a gastrostomy tube (also called a G-tube, enteral tube, or feeding tube) for Resident #49. The facility failed to ensure CNA C and CNA D wore proper PPE during incontinent care for Resident #10 who required enhanced barrier precautions. CNA C cleaned front to back during incontinent care for Resident #10. CNA C and CNA D properly changed gloves and performed hand hygiene during incontinent care for Resident #10. The facility failed to ensure CNA E properly changed gloves and performed hand hygiene during incontinent care for Resident #8. The facility failed to ensure Resident #3 had EBP signage and PPE readily available for dressing changes. This failure could place residents at risk of not receiving quality care and services. The findings include: Observation and interview with Resident #3 on 07/06/26 at 3:19 pm, she said she had a pressure ulcer on her bottom, which she got at the facility. She said it hurts. She said she had never seen any of the staff wear a gown when they changed her dressings. She said she had other dressings they changed on her right BKA, left toes, and right wrist. There was no signage outside the door, on the door, or inside the room. There was no PPE readily available, neither outside nor inside the room. Observation of Resident #3's room on 07/07/26 at 9:24 am revealed no signage outside the door, on the door, or inside the room. There was no PPE readily available, neither outside nor inside the room. In an interview with the RNC, WCN, DON, and ICP on 07/07/26 at 2:33 pm, the WCN said Resident #3 was getting dressing changes daily. She said Resident #3 had an acquired sacrum pressure ulcer, L 1st big toe, and a right BKA. She said Resident #3 should be on EBP. She said there were orders for EBP on 06/22/26 and 07/07/2026. She said she did not use gowns during dressing changes for Resident #3 and could not say why. The DON said there probably was not a sign up in her room and did not know why. ICP said she was responsible for EBP and ran antibiotic orders once a week and at the end of each month. She said if residents were not on antibiotics, she printed the order listing to see if EBP was ordered. She said she was not familiar with the facility's policy on EBP. She said she thought only open wounds needed EBP. The RNC said if there were wounds requiring dressing changes, that included surgical sites, the right outer wrist, right BKA, and acquired pressure ulcers. The WCN said there was a DTI on the sacrum/intact blister, and it got staged as a stage II. She said Resident #3 was admitted on [DATE] with a surgical incision/site, and dressing changes were ordered. She said Resident #3 was supposed to be on EBP, but never was. The ICP said all nursing should know about qualifying wounds and dressing changes should be on EBP. The ICP (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said she usually did in-services, and it was in the orders to initiate EBP on Resident #3. The DON said residents who were supposed to be on EBP but were not could put others at risk for infections, meaning families, children, staff, and other residents. The ICP said the last hand-washing in-service was about 2 months ago and they had hand-washing demonstration skills for 20 seconds of vigorous lathering, and at least one minute in total. The ICP was not sure when the last in-service for EBP was done. She said she was responsible for surveillance and monitoring for infection control. She said nothing when asked why Resident was not on EBP. The RNC said she would conduct facility-wide in-services for all staff and administration pertaining to hand washing, wound care, EBP, and glove changes. During an observation on 7/07/2026 at 11:00 a.m., LVN B administered medications to Resident #49 through his G-tube. LVN B wore gloves during the administration and did not wear a PPE gown. The EBP sign was posted at the entrance to Resident #49's room. During an interview on 7/07/2026 at 11:10 a.m., LVN B said she should have worn a gown during medication administration for Resident #49. She said it was important to follow EBP for infection control. She said there was no negative outcome for Resident #49 from not wearing appropriate PPE. LVN B said the last in-service on EBP and TBP was in June 2026. During an observation on 07/07/26 at 1:55 pm, the WCN was observed washing her hands for approximately 6 seconds prior to providing wound care for Resident #1. CNA A was observed washing her hands for approximately 4 seconds prior to assisting the WCN with Resident #1's wound care. During Resident #1's wound care, the WCN removed her gloves and did not perform hand hygiene before continuing the wound care procedure. Following the completion of Resident #1's wound care, the WCN was observed washing her hands for approximately 5 seconds. In an interview on 07/07/26 at 2:18 pm, the WCN stated hands should be washed for approximately 10 to 15 seconds to help prevent the spread of infection. The WCN stated hand hygiene should be performed after glove removal. The WCN stated she believed she had sanitized her hands after removing her gloves. The WCN further stated that if Resident #1's wound came into contact with bacteria, the wound could worsen or fail to heal. In an interview on 07/07/26 at 2:24 pm, CNA A stated hands should be washed for approximately 20 to 30 seconds to remove any germs from the hands. CNA A stated that if Resident #1's wound came into contact with any germs, the wound could become infected. In an interview on 07/07/26 at 2:39 pm, the ICP stated handwashing should be performed for at least 20 seconds with lathering to help prevent the spread of infection. The ICP stated that if hand hygiene was not performed correctly, germs could be transferred to the residents. The ICP further stated that hand hygiene should be performed after every glove removal by washing hands or using hand sanitizer. In an interview on 07/08/26 at 8:36 am, the DON stated handwashing should be performed for approximately 20 seconds to clean off all the germs with friction and soap combined. The DON stated that if Resident #1's wound came into contact with germs, it could worsen or delay the healing process due to possible infection. During an observation beginning on 07/08/26 at 8:51 am, a sling used for a mechanical lift transfer and a heel protector were observed drying on the dirty side of the laundry area. In an interview on 07/08/26 at 9:00 am, the ES stated that after slings and heel protectors were washed, the slings were hung to dry, and the heel protectors were placed on top of a rack located at the entrance of the dirty side of the laundry area. The ES stated there was no other location available for the items to dry, and that was the process she had been taught. The ES stated she did not believe the practice was incorrect because the items had been washed. During an observation of one of the lint traps located underneath the dryer on 07/08/26 at 9:05 am, the ES stated that was the first load of laundry drying that morning and that she planned to clean the lint trap after the load had finished. The ES stated the previous night shift had washed the laundry and left it in the washer overnight, and she transferred the laundry to the dryer upon arriving for work that (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changed when they were visibly soiled and when placing a new brief. He said he had not changed gloves when he applied the clean brief. CNA C said hand hygiene was done before putting on clean gloves. He said he had a web-based in-service on infection control this year, 2026. CNA C said it was important to follow infection control measures to avoid the spread of disease. During an interview on 7/08/26 at 2:27 p.m., the ICP said she provided training for the CNAs for peri-care. She said new CNAs worked three days and checked their skills check-off for peri-care and infection control. The ICP said the CNAs skills checkoffs were completed upon hire and annually. She said training continued for a CNA that needed improvement. The ICP said CNA C, CNA D, and CNA E were up to date with their skills check-offs for infection control and peri-care. She said she expected the staff to completely understand the process and why infection control was important. During an interview on 7/08/26 at 2:52 p.m., the DON said she expected staff to follow infection control policies and procedures. She said the annual competency checklists were completed with the CNAs. The DON said she had not noticed an increase in UTIs and monitored increased trends in infections. She said she provided in-services on infection control quarterly and as needed, through the facility's web-based education portal. Record review beginning on 07/06/26 of the facility's infection prevention audits, infection control surveillance, and QAPI documentation revealed no evidence the facility identified, monitored, trended, or implemented corrective actions related to hand hygiene, PPE use, Enhanced Barrier Precautions, wound care practices, G-Tube medication administration, or laundry processes. Multiple infection prevention deficiencies were identified during the survey affecting five of the eighteen sampled residents (Residents #1, Resident #49, Resident #8, Resident #10, and Resident #3), these issues were not identified through the facilities infection prevention monitoring or QAPI activities. In an interview on 07/08/26 at 1:54pm, the ADM stated that the QAA committee met once a month and as needed. The ADM stated the facility had not identified any systemic infection control concerns through its QAPI program, and there was no current PIP related to infection control. The ADM stated that the ICP was responsible for overseeing the Infection Prevention and Control Program. During a concurrent interview, the ICP stated she was unaware that infection control oversight included monitoring the dietary and laundry departments and that she had not conducted routine infection control surveillance or monitoring in those areas. Despite the facility's failure to identify infection control concerns, the survey team identified infection control deficient practices in the dietary, laundry, and nursing departments during the survey. Record review of the facility's Quality Assessment Assurance Committee policy dated 10/24/22 reflected: Policy This facility will maintain a Quality Assessment and Assurance (QAA) Committee to identify quality issues and develop appropriate plans of action to correct quality deficiencies through an interdisciplinary approach. 2. The infection preventionist must be a member of the QAA committee and report to the committee on the infection prevention and control program (IPCP) and incidents (eg., healthcare-associated infections (HAIs) identified under the program on a regular basis.) i. Facility process and outcome surveillance		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed 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, for five of eighteen residents (Resident #1, Resident #49, Resident #8, Resident #10, and Resident #3), and one of one laundry rooms reviewed for infection control and transmission-based precautions policies and practices.1. The facility failed to ensure the WCN performed hand hygiene for at least 20 seconds prior to and after performing Resident #1's wound care and performed hand hygiene after glove removal. CNA A performed hand hygiene for at least 20 seconds prior and after assisting the WCN with Resident #1's wound care.2. The facility failed to ensure the ES maintained the integrity of clean laundry by hanging laundered slings and heel protectors on the dirty side of the laundry area instead of the clean side. Laundry staff dried wet linen and resident clothing after washing them. 3. The facility failed to ensure LVN B put on a gown prior to administering medication through a gastrostomy tube (also called a G-tube, enteral tube, or feeding tube) for Resident #49.4. The facility failed to ensure CNA C and CNA D wore proper PPE during incontinent care for Resident #10 who required enhanced barrier precautions. CNA C cleaned front to back during incontinent care for Resident #10. CNA C and CNA D properly changed gloves and performed hand hygiene during incontinent care for Resident #10.5. The facility failed to ensure CNA E properly changed gloves and performed hand hygiene during incontinent care for Resident #8.6. The facility failed to ensure Resident #3 had EBP signage and PPE readily available for dressing changes. These failures could place residents who require wound care, incontinent care, and isolation at risk for healthcare-associated cross-contamination and infections. The findings included:1. Record review of Resident #1's face sheet dated 07/07/26 reflected an [AGE] year-old-male with an original admission date of 01/18/26. Diagnosis included stage 3 (full-thickness skin loss, with exposure of the fatty tissue beneath) pressure ulcer (injuries to the skin and underlying tissues caused by prolonged pressure on the skin) to the right heel, dementia ((loss of memory, language, problem solving and other thinking abilities which significantly impairs a person's ability to perform daily activities), Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills) and type 2 diabetes (insufficient insulin production in the body). Record review of Resident #1's significant change MDS dated [DATE] reflected that he had an unhealed stage 3 pressure ulcer and was at risk of developing more. Record review of Resident #1's physician orders dated 07/03/23 reflected: Cleanse stage 3 pressure ulcer with normal saline wound cleanser, pat dry, and apply Santyl (medication designed to debride chronic skin ulcers, severe burns, and other wounds), then apply calcium alginate (gel-like, cream-colored material used to promote wound healing) and cover with a dry dressing. Wrap with kerlix (woven gauze dressing used primarily for wound care). Change dressing daily and as needed if saturated, loose, or soiled. Assess wound for size, drainage, odor, redness, warmth, and signs of infection. Notify the provider of increased drainage, odor, surrounding redness, swelling, pain, or wound deterioration. Record review of Resident #1's care plan reflected: Resident #1 has a stage 3 pressure ulcer to the right heel initiated on 03/29/26. Interventions included: Administer treatments as ordered and monitor for effectiveness. Resident #1 has the need for enhanced barrier protection due to open wound initiated on 04/01/26. Interventions included: Use non-shared resident medical equipment if possible. Disinfect shared equipment with the appropriate disinfectant. Assess for signs and symptoms of infection, such as: Increased white blood (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cell count, fever, redness, swelling, purulent drainage of areas of non-intact skin, changes in urine or sputum, and report to the nurse practitioner and medical doctor as indicated. Assess the resident for risk factors or current injuries or treatments that could put the patient at risk for infection (wounds, central lines, drains, catheters, Tracheostomy). During an observation on 07/07/26 at 1:55 pm, the WCN was observed washing her hands for approximately 6 seconds prior to providing wound care for Resident #1. CNA A was observed washing her hands for approximately 4 seconds prior to assisting the WCN with Resident #1's wound care. During Resident #1's wound care, the WCN removed her gloves and did not perform hand hygiene before continuing the wound care procedure. Following the completion of Resident #1's wound care, the WCN was observed washing her hands for approximately 5 seconds. In an interview on 07/07/26 at 2:18 pm, the WCN stated hands should be washed for approximately 10 to 15 seconds to help prevent the spread of infection. The WCN stated hand hygiene should be performed after glove removal. The WCN stated she believed she had sanitized her hands after removing her gloves. The WCN further stated that if Resident #1's wound came into contact with bacteria, the wound could worsen or fail to heal. In an interview on 07/07/26 at 2:24 pm, CNA A stated hands should be washed for approximately 20 to 30 seconds to remove any germs from the hands. CNA A stated that if Resident #1's wound came into contact with any germs, the wound could become infected. In an interview on 07/07/26 at 2:39 pm, the ICP stated handwashing should be performed for at least 20 seconds with lathering to help prevent the spread of infection. The ICP stated that if hand hygiene was not performed correctly, germs could be transferred to the residents. The ICP further stated that hand hygiene should be performed after every glove removal by washing hands or using hand sanitizer. In an interview on 07/08/26 at 8:36 am, the DON stated handwashing should be performed for approximately 20 seconds to clean off all the germs with friction and soap combined. The DON stated that if Resident #1's wound came into contact with germs, it could worsen or delay the healing process due to possible infection. 2. During an observation beginning on 07/08/26 at 8:51 am, a sling used for a mechanical lift transfer and a heel protector were observed drying on the dirty side of the laundry area. In an interview on 07/08/26 at 9:00 am, the ES stated that after slings and heel protectors were washed, the slings were hung to dry, and the heel protectors were placed on top of a rack located at the entrance of the dirty side of the laundry area. The ES stated there was no other location available for the items to dry, and that was the process she had been taught. The ES stated she did not believe the practice was incorrect because the items had been washed. During an observation of one of the lint traps located underneath the dryer on 07/08/26 at 9:05 am, the ES stated that was the first load of laundry drying that morning and that she planned to clean the lint trap after the load had finished. The ES stated the previous night shift had washed the laundry and left it in the washer overnight, and she transferred the laundry to the dryer upon arriving for work that morning. The ES further stated that because the laundry was washed with chemicals in an industrial washer, she believed it was acceptable to leave the wet laundry in the washer overnight. The ES stated that was how she was trained when she first started, and that was the way it was done. In an interview on 07/08/26 at 10:26 am, the ICP stated she had served as the Infection Control Preventionist for approximately 2 years. The ICP stated she oversaw all of the facility's infection prevention and control program in conjunction with the DON. The ICP stated she was unaware that infection control oversight included monitoring the dietary and laundry departments and that she had not conducted routine infection control surveillance or monitoring in those areas. The ICP stated that slings and heel protectors should not be hung to dry on the dirty side of the laundry area because they could become contaminated by airborne microorganisms. The ICP further stated that washed, wet linen should not be left in the washer overnight because microorganisms could grow on the linen. 3. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Live Oak Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2951 Hwy 281 George West, TX 78022	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #49's face sheet, dated 7/7/26, reflected a [AGE] year-old male with an admission date of 3/8/25. His relevant diagnoses included dysphagia (difficulty or discomfort in swallowing), gastrostomy status (surgically created opening directly into the stomach, typically used for a feeding tube), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills).Record review of Resident #49's quarterly MDS assessment, dated 6/8/26, reflected a BIMS score of 7, which indicated severe cognitive impairment. Section K, titled swallowing/nutritional status, indicated he had a feeding tube while was a resident.Record review of Resident #49's care plan, dated 3/24/25, reflected Resident #49 has the need for Enhanced Barrier Precautions due to gastronomy. Interventions: Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures: Gown and gloves only for high-contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Use a mask, goggles/eye shields as indicated.Record review of Resident #49's physician order, dated 7/8/26, indicated EBP: Use gown and gloves for high contact resident care activities for those who are known to be colonized or infected with a CDC-targeted MDRO, as well as those with increased risk of MDR. (residents with wounds or indwelling medical devices) every shift. Start date 5/8/25.During an observation on 7/07/2026 at 11:00 a.m., LVN B administered medications to Resident #49 through his G-tube. LVN B wore gloves during the administration and did not wear a PPE gown. The EBP sign was posted at the entrance to Resident #49's room.During an interview on 7/07/2026 at 11:10 a.m., LVN B said she should have worn a gown during medication administration for Resident #49. She said it was important to follow EBP for infection control. She said there was no negative outcome for Resident #49 from not wearing appropriate PPE. LVN B said the last in-service on EBP and TBP was in June 2026.Record review of Resident #10's face sheet, dated 7/8/26, reflected a [AGE] year-old male with an admission date of 7/3/25. His relevant diagnoses included osteomyelitis of vertebra (a serious but treatable infection of the bones in the spine) and malignant neoplasm of unspecified bronchus or lungs (a cancerous tumor in the lungs or breathing tubes).Record review of Resident #10's comprehensive MDS assessment, dated 5/11/26, reflected a BIMS score of 10, which indicated moderate cognitive impairment.Record review of Resident #10's care plan, dated 2/17/26, reflected Resident #10 has the need for Enhanced Barrier Precautions due to: Hx of MSSA. Interventions: Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures: Gown and gloves only for high-contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Use a mask, goggles/eye shields as indicated.Record review of Resident #10's physician orders, dated 7/08/26, indicated Enhanced Barrier Precautions: Use gown and gloves for high contact resident care activities for those known to be colonized or infected with a CDC targeted MDRO as well as those with increased risk of MDR. (residents with wounds or indwelling medical devices). Order date: 3/4/26.During an observation on 7/08/26 at 9:27 am, CNA C and CNA D entered Resident #10's room for incontinent care. CNA C and CNA D performed hand washing, donned gloves, and did not don PPE gown. EBP sign was posted at the entrance to Resident #10's room.During an interview on 7/08/26 at 9:40 am, CNA D said she was not aware Resident #10 required EBP. She said she was supposed to wear PPE when performing incontinent care for Resident #10. She said the nurses informed her whenever a resident was under EBP. She said it was important to wear PPE because of germs and transferring germs from one to another. CNA D said she had reviewed videos on infection control in June 2026.During an (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wearing the same soiled gloves. Both CNAs removed their PPE and performed handwashing before leaving the room. During an interview on 7/8/26 at 10:27 a.m., CNA E said clean gloves were changed when placing a clean brief on a resident. She said she did not change her gloves when she had placed the clean brief for resident #8. She said hand hygiene was performed after removing gloves. CNA E said she had an in-service on peri-care and handwashing in July 2026. She said it was important to follow infection control to avoid contamination, spreading germs, and infection control was followed as a precaution. During an interview on 7/08/26 at 2:27 p.m., the ICP said she provided training for the CNAs for peri-care. She said new CNAs worked three days and checked their skills check-off for peri-care and infection control. The ICP said the CNAs skills checkoffs were completed upon hire and annually. She said training continued for a CNA that needed improvement. The ICP said CNA C, CNA D, and CNA E were up to date with their skills check-offs for infection control and peri-care. She said she expected the staff to completely understand the process and why infection control was important. During an interview on 7/08/26 at 2:52 p.m., the DON said she expected staff to follow infection control policies and procedures. She said the annual competency checklists were completed with the CNAs. The DON said she had not noticed an increase in UTIs and monitored increased trends in infections. She said she provided in-services on infection control quarterly and as needed, through the facility's web-based education portal. 6. Record review of Resident #3's face sheet dated 06/19/26 revealed a [AGE] year-old female with an admission date of 06/19/26. Relevant diagnoses included UTI, diabetes with neuropathy (nerve damage), and foot ulcer (sore, open wound, or skin crater), high blood pressure, muscle wasting, peripheral vascular disease (a slow, progressive disorder where blood vessels outside the heart and brain-typically in the legs and feet- narrow, spasm, or become blocked), osteomyelitis (bone infection), ESBL (extended spectrum beta-lactamase is an enzyme found in some strains of bacteria. ESBL producing bacteria cannot be killed by many common antibiotics. This makes it harder to treat) resistance, right lower extremity surgical amputation, and abnormalities of gait and mobility. Record review of Resident #3's admission MDS dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive impairment with inattention and disorganized thinking. She could ambulate with assistance and a walker. She could self-propel her wheelchair. She required substantial assistance with lower body dressing, moderate assistance with toileting, transfers, and bathing, supervision with upper body dressing and positioning, and was independent with rolling, eating, and oral hygiene. She was frequently incontinent of bladder and continent of bowel. Her active diagnoses were medically complex and included MDRO/ESBL (a superbug that produces a special shield that destroys many common antibiotics and is very hard to treat) and UTI. She had one Stage I pressure injury and three unstageable pressure ulcers upon admission; an infection of the foot, diabetic foot ulcers, and a surgical wound. She required pressure ulcer care, surgical wound care, application of dressings, ointments/medications, and applications of dressings to her foot. Record review of Resident #3's care plan dated 06/20/26 revealed: Problem: The resident has impaired immunity r/t hx of ESBL (present on admission). Date Initiated: 07/07/2026. Interventions included: Use universal precautions as appropriate. Date Initiated: 07/07/2026. Problem: Resident has the need for Enhanced Barrier Precautions due to: hx of ESBL, wound. Is at risk for infection, depression, feelings of isolation, and decline in physical activity. Date Initiated: 07/07/2026. Interventions included: Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures: Gown and gloves only for high- contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Use a mask, goggles/eye shield as (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated. Date Initiated: 07/07/2026. Problem: The resident has potential/actual impairment to skin integrity of the lower extremity r/t PVD (peripheral vascular disease, which is poor circulation in the body. Most often, it means clogged, narrowed, or blocked vessels in the legs and feet). The resident has potential/actual impairment to skin integrity of the right lower extremity r/t BKA surgical site. The resident has potential/actual impairment to skin integrity of the right wrist area of concern r/t unknown. Present upon admission. The resident has a potential/actual impairment to skin integrity, abrasion of the right 2nd toe. Date Initiated: 06/20/2026. Resolved 6/29/26. Interventions did not include EBP. Problem: The resident has occasional bladder incontinence r/t immobility. HX of UTI with admission from the hospital. Date Initiated: 06/27/2026. Interventions did not include EBP. Record review of Resident #3's Change of condition documentation dated 06/20/26 revealed drainage noted to left great toe to unstageable wound. Primary diagnoses- BKA to right extremity. Charge nurse performed wound care to left great toe, after cleansing wound with normal saline and pat dry, an unstageable wound to left great toe had drainage. Record review of Resident #3's Skin check dated 06/22/26 revealed a medial right shin issue, a surgical wound present on admission, a right gluteus (buttocks) unstageable pressure ulcer/injury present on admission, a left dorsum (top) foot, an in-house acquired medial left heel stage I pressure injury, an unstageable left gluteus pressure ulcer/injury present on admission, an unstageable left dorsum great toe pressure ulcer/injury present on admission, a left second toe abrasion present on admission, a right outer wrist wound present on admission, and a right lower quadrant (abdomen) bruise present on admission. Record review of Resident #3's active physician orders revealed Enhanced Barrier Precautions: Use gown and gloves for high contact resident care activities for those with known to be colonized or infected with a CDC-targeted MDRO, as well as those with increased risk of MDRO (residents with wounds or indwelling medical devices) every shift for Hx. ESBL- Blood. Prescriber Written Active 06/22/2026. Record review of Resident #3's Change of condition documentation dated 07/03/26 revealed stage 2 pressure ulcer/intact blister to right upper medial buttocks due to friction. Intact t blister stage 2 ulcer to right upper medial buttocks-not a reopening of previous ulcer. Record review of Resident #3's Change of condition documentation dated 07/06/26 revealed a decline in stage 2 ulcer to buttocks. Record review of Resident #3's progress notes dated 06/19/26 revealed 3 new skin issues (as described above). Skin Issues Note: resident admitted with wounds, staged by in-house nursing and referred to local wound management. Skin issue education included dressing change(s), care of skin issue(s), signs and symptoms of infection, treatment of skin issue, moisture barrier, change clothing/briefs, change/shift positions frequently, and turn every 2 hours. Skin issue notification: Family and Wound nurse. Observation and interview with Resident #3 on 07/06/26 at 3:19 pm, she said she had a pressure ulcer on her bottom, which she got at the facility. She said it hurts. She said she had never seen any of the staff wear a gown when they changed her dressings. She said she had other dressings they changed-on her right BKA, left toes, and right wrist. There was no signage outside the door, on the door, or inside the room. There was no PPE readily available, neither outside nor inside the room. Observation of Resident #3's room on 07/07/26 at 9:24 am revealed no signage outside the door, on the door, or inside the room. There was no PPE readily available, neither outside nor inside the room. In an interview with the RNC, WCN, DON, and ICP on 07/07/26 at 2:33 pm, the WCN said Resident #3 was getting dressing changes daily. She said Resident #3 had an acquired sacrum pressure ulcer, L 1st big toe, and a right BKA. She said Resident #3 should be on EBP. She said there were orders for EBP on 06/22/26 and 07/07/2026. She said she did not use gowns during dressing changes for Resident #3 and could not say why. The DON said there probably was not a sign up in her room and did not know why. ICP said she was responsible for EBP and ran antibiotic orders (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	once a week and at the end of each month. She said if residents were not on antibiotics, she printed the order listing to see if EBP was ordered. She said she was not familiar with the facility's policy on EBP. She said she thought only open wounds needed EBP. The RNC said if there were wounds requiring dressing changes, that included surgical sites, the right outer wrist, right BKA, and acquired pressure ulcers. The WCN said there was a DTI on the sacrum/intact blister, and it got staged as a stage II. She said Resident #3 was admitted on [DATE] with a surgical incision/site, and dressing changes were ordered. She said Resident #3 was supposed to be on EBP, but never was. The ICP said all nursing should know about qualifying wounds and dressing changes should be on EBP. The ICP said she usually did in-services, and it was in the orders to initiate EBP on Resident #3. The DON said residents who were supposed to be on EBP but were not could put others at risk for infections, meaning families, children, staff, and other residents. The ICP said the last hand-washing in-service was about 2 months ago and they had hand-washing demonstration skills for 20 seconds of vigorous lathering, and at least one minute in total. The ICP was not sure when the last in-service for EBP was done. She said she was responsible for surveillance and monitoring for infection control. She said nothing when asked why Resident was not on EBP. The RNC said she would conduct facility-wide in-services for all staff and administration pertaining to hand washing, wound care, EBP, and glove changes. In an interview with CNA E on 07/08/2026 at 8:57 am, she said the CNAs did rounds every 2 hours or more as needed and spot rounds, especially with incontinent patients. She said signs on the doors indicated EBP or Isolation. She said several residents got new signs yesterday because they were supposed to be on EBP but were not. She said Resident #3 was one of them. She said the signs and PPE were important for staff and visitors for protection from open sores or wounds, and so we did not take anything (germs) home. She said the purpose of EBP was to prevent cross-contamination among other residents and themselves (staff). She said she felt wrong about not having used EBP, but she did not know. She said the nurses were not on it to gown up, meaning they did not enforce it-she said, it was lazy and neglectful. She would not name the staff. She said the ICP was supposed to be responsible for making sure the signs and PPE were in place. She said the signs and PPE should be posted immediately to prevent any cross-contamination. Record review of the facility's Hand Hygiene policy dated 10/24/22 reflected: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 3. Hand hygiene technique when using soap and water: c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. 5. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Record review of the facility's Infection Prevention and Control Program policy dated 05/13/23 reflected: Policy This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. 12. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent the spread of infection. Record review of the facility's laundry procedures reflected: 4) Drying Linens should be moved from washer to dryer as quickly as possible. Record review of the facility's policy titled Enhanced Barrier Precautions, dated 11/24/25, stated, Policy Explanation and Compliance Guidelines: 1. c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of PPE prior to providing high-contact care activities. 3. a. Make gowns and gloves available near or outside of the resident's room. b. PPE for enhanced barrier precautions is only necessary when (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment, for one of eighteen residents (Resident #39) that were observed for a safe, comfortable, homelike environment. The facility failed to ensure temperatures in Resident #39's restroom did not rise above 81 F for approximately one month. This failure could place residents at risk of decreased quality of life and comfort. The findings include: Record review of Resident #39's face sheet dated 07/07/26 reflected an [AGE] year-old-female with an original admission date of 08/10/24. Diagnoses included Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), dementia (loss of memory, language, problem solving and other thinking abilities which significantly impairs a person's ability to perform daily activities), type 2 diabetes (insufficient insulin production in the body), anemia, and hypertension (high blood pressure). Record review of Resident #39's quarterly MDS dated [DATE] reflected a BIMS score of 6 (severe cognitive impairment). Resident #39 used a walker and was independent for eating, toileting, oral hygiene, shower/bathe, dressing, and personal hygiene. During an interview on 07/06/26 at 2:34pm, Resident #39 stated her room and restroom were hot and she was very uncomfortable. She reported her family had brought in two fans, but they had not helped much. Resident #39 stated she had previously reported the issue to staff, but nothing appeared to have been done. She stated she liked to spend most of her day participating in activities and is not in her room often. Resident #39 stated staff would bring her cold water whenever she wanted, but she was usually not in her room during the day and stayed cooled for the most part. During an observation on 07/06/26 at 2:52pm, a temperature of 80.3 F in Resident #39's room and a temperature of 83.4 F in the restroom. During an observation and interview on 07/06/26 at 3:10pm, the ADM entered Resident #39's room and used the facility's temperature gun to obtain a reading of 79.3 F in Resident #39's room and a temperature of 87.7 F in the restroom. The ADM stated he believed the room felt warmer because Resident #39 kept her blinds open, allowing direct sunlight into the room. He further stated Resident #39 kept her restroom door closed, and that a high window in the restroom allowed additional sunlight into the area. The ADM stated that leaving the restroom door open could help cool the room. The ADM further stated Resident #39 had previously informed him that her room was hot (date unknown). The ADM stated that the MD adjusted the air vent and sealed the windows from the outside and inside to reduce heat infiltration and prevent conditioned air from escaping. The ADM stated staff ensured Resident #39 was hydrated and offered cold water often. The ADM stated Resident #39's family later brought in two fans, which he believed helped, and that the resident did not raise the concern again. In an interview on 07/06/26 at 3:18pm, Resident #5, the roommate of Resident #39, stated she was always cold and had no issue with the room or the restroom being hot. In an interview on 07/06/26 at 3:28pm, the MD stated the facility planned to replace the exhaust manifold located above Resident #39's room. The MD stated the air conditioning vent was blowing cold air but because the exhaust manifold was not functioning properly, the cooled air was being exhausted from the room. The MD stated the exhaust manifold had not been functioning properly for approximately one month but was unsure of the exact time frame. The MD stated the facility had ordered the replacement part through one vendor, but they were unable to obtain it. The facility then ordered the part through a different vendor, and the MD stated it was expected to arrive and be replaced within the next one to two days if not today. The MD stated he was obtaining temperature readings in Resident #39's room and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Live Oak Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2951 Hwy 281 George West, TX 78022	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restroom, and the temperature would stay around 77 F in the room and up to about 84 F in the restroom. On 07/07/26 at 9:10am, Resident #39 and Resident #5 were relocated to another room until the repairs could be completed. The ADM stated that the repairs would be completed by the end of the day. Record review of the facility's Statement of Rights not dated reflected: You have the right to: (1) all care necessary for you to have the highest possible level of health; (2) safe, decent and clean conations		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interviews the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the residents needs, in one of one medication room reviewed for safe medication storage.The facility failed to dispose of expired influenza vaccines stored in the refrigerator in the medication room.This failure could place residents at risk of receiving medications which were expired.The findings include:During an observation of the medication storage room on 7/7/26 at 7:21 a.m., ten unopened boxes of influenza vaccines with an expiration date of 6/30/2026 were in the refrigerator in the medication storage room.During an interview on 7/7/26 at 7:35 a.m., the ADON said the influenza vaccines were given between October 2025 through March 2026. She said the vaccines were not given during this time. The ADON said the facility received the vaccines during the flu season which began in October 2025. She said the left-over flu vaccines were disposed of by the pharmacist once the flu season was over. The ADON said she was responsible for checking expired medication and disposing of medication as needed. She said the pharmacy consultant performed in-services on disposing medication and checked for expired medication. The ADON said the last in-service on disposing of medication was in May 2026. She said there were no negative outcomes to the residents as residents did not receive flu vaccines in June 2026.During an interview on 7/08/26 at 2:52 p.m., the DON said in March 2026 was the last time influenza vaccines were administered to the residents. She said the ADON monitored expiration dates and removed medications from the medication storage room. The DON said her expectation from the staff was that they removed expired medication from the medication storage room and medication carts. She said the pharmacy consultant came to the facility every month and checked for expired medication in the medication storage room and medication carts.Record review of the facility's policy titled Expiration Dating and Expired Medication, dated 10/01/19, stated Policy- Drugs which have been dispensed for individual residents, are not to be used beyond the expiration date indicated by the manufacturer, by the pharmacy, or based on the following criteria. The facility is to strictly adhere to the expiration dating. Procedure- .8. It is the responsibility of all nurses who administer medications to monitor the expiration dates of the medications. Expired medications will not be administered in the facility. All expired medications will be disposed of per facility policy.		